SOUTH AFRICAN SOCIETY FOR MENTAL HEALTH AND DEAFNESS

EXCOPLUS CONFERENCE ON 18 OCTOBER 2024

CONTENTS



A new initiative for Deaf- and DeafBlind-accessible and friendly Mental Health services and programs at primary, secondary, and tertiary levels has commenced in collaboration with academic departments and mental health professionals.

This initiative aims to engage all relevant parties to join the outreach to D/deaf and DeafBlind communities, schools, vulnerable people, and families to have accessible mental health services and programs at primary, secondary, and tertiary levels and enjoy optimal health and well-being.

# REPORT

# SOUTH AFRICAN SOCIETY FOR MENTAL HEALTH AND DEAFNESS (SASMHD)

**EXCOPLUS CONFERENCE ON 18 OCTOBER 2024 REPORT**

**FOREWORD**

**THE CONFERENCE WAS AN INSPIRING, INFORMATIVE AND EDIFYING EXPERIENCE**

## 1. ATTENDANCE

The conference was attended by 25 persons of diverse backgrounds and professions (visit the Attendance List on the last page of this document). The Conference notes that Mr. Bruno Druchen, CEO of DeafSA, was admitted to the hospital. He followed part of the proceedings online from there. We pray for his speedy recovery.

Conference organiser: Please be patient. We are experiencing connectivity challenges in some areas, and we will commence at 09h00.

## 2. OPENING ADDRESS: MR TIM STONES SASMHD CHAIRPERSON

Mr Stones, a Deaf Professional, is a senior sub-editor with the Media House Tiso Blackstar and is attached to the Daily Dispatch in East London. He is also a Minister and is currently preparing for ordination as a First Responder Chaplain. His undergraduate degree was a BA (English, Philosophy, Religious Studies) at UCT (1999). In addition, he holds a Pg Dip in Journalism (Rhodes, 2006).

He completed the preliminary year of the postgraduate LLB at Rhodes in 2000.

He has also completed courses through the Theological Education by Extension College (TEEC) - Preaching, Pastoral Care, HIV/Aids and Spirituality in Africa, and Introduction to Spirituality.

While employed with the DeafNET Centre of Knowledge, he completed the train-the-trainer courses on the impact of deafness, which led to subsequent experience leading workshops on this issue and conducting accessibility audits (for example, throughout Rhodes University in 2012, when he was employed as Disability Advisor in the Dean of Students Division).

He matriculated in the first class from St Andrew's College, in Grahamstown, in 1996.

## OPENING ADDRESS

Good morning friends and colleagues, and a special warm welcome to our esteemed guests and keynote speakers to what will no doubt be a fascinating scientific conference from which we hope we will all depart filled with new insights and knowledge, and inspired and refreshed to go out and do the necessary work and make the changes we must make to ensure that mental health services can be received by Deaf and Deafblind people at the best possible level.

In this opening address, I would like to share briefly some of my own experiences as a deaf person who has had to make use of mental health services at various times in my adult life. You will hear how some of my earlier experiences were made worse, with incorrect diagnoses and improper treatment, while with changes in communication strategies and support, I have been able to access better, correct and helpful treatment. What is significant in my experience is that I would probably be described as an empowered deaf person, who can communicate more freely in a hearing world, and access key resources. And yet despite my apparent advantages, I have still had some terrible experiences with mental health services. How much more, then, can we appreciate and empathise with people who rely on sign language to communicate, and who are less able to communicate their needs and challenges. It is this fact that makes SASMHD an essential service, and why this conference and its outcomes will be crucial to determining the best possible mental health support and related services for Deaf and DeafBlind people throughout South Africa.

A bit more than 20 years ago I had a complete breakdown. Having rushed into my first marriage, renting a new home with an alcoholic landlord whose son had trouble with the police, trying to juggle two jobs while studying towards a Master’s degree – and finding that the person I thought I had married was very different after the fact – sent me into a rapid downward spiral, where things quickly escalated and I found myself severely depressed. After just one session with a psychiatrist, which my wife attended – and in which most of the communication was between the psychiatrist and my wife, with little attempt to ensure I was able to fully understand what I was being asked, or to understand what I was trying to say – I was put on a heavy medication, that caused a dystonic reaction while I was running just a few days later. I was unable to speak, or stand on my own, and had to be taken to hospital and put on a drip.

A short while after this I attempted to take my life for the first time. Initially, after being stabilised at Groote Schuur hospital, I was placed in the hospital's psychiatric ward, for a few days. I don't remember and could not follow what was being said or what was going on.

I suspect that because I withdrew even more because of feeling insecure and not being able to understand what was going on or being said, in that setting it made professionals believe things were worse than they really are. I say this because after a few days I found myself, without any attempt to clearly communicate with me the reasons for it or even what was about to happen, I found myself forced into an ambulance, and taken to Valkenburg hospital, where I was placed in a ward for the people who are most severely ill.

For two weeks I endured a horrendous situation, one in which I knew I was not crazy, just very depressed, and the situation only made my depression worse – placed among people who were actively psychotic, and some of whom were dangerous. I slept on a worn out mattress on the floor, with no safe space to keep my hearing aids – so kept them on even at night, which wore out the batteries, resulting in my not being able to hear after a few days. I did not have access to my cellphone, so could not communicate with anyone to ask for help or more batteries, or even to try writing down what was actually going on inside my mind when eventually being able to see a doctor again. When I told the doctor I was deaf and could not clearly read her lips, she just stared at her piece of paper, writing. Then without addressing me, nodded at the guards, and I was taken back to the ward and again locked in.During that time I woke up one evening to find one of the other patients over me, his hand in my pants, feeling me up. I was very drugged up at this point, again without being helped to understand why I was on these heavy medications, and could not fight back. I called for help, but no one came. Later I got up and stood at the entrance to the ward, calling the guards. I could see them around the door, playing cards. No one came.

After about two weeks I found myself suddenly taken to a better ward, with people who were more like I felt, depressed, but not psychotic. However, again in that ward I spent most of my days alone, without any doctors speaking with me. When they did, they would come to the ward, and speak with others in the lounge area. Obviously I could not speak freely. Finally, after another two weeks had passed, my mother came to the hospital and forced a meeting with the hospital's director. At that meeting I found myself in a large room with around 15 to 20 other specialists, all of whom fired questions at me from every corner of the room. It was impossible for me to follow everything, and my appeal for them to consider my hearing loss seemed to fall on their own deaf ears.

I imagine my mother must have said something because I don't recall what was asked at the meeting but the end result was that I was discharged into my mother's care. She started me on a process to detox from the cocktail of medications I had been subjected to. For more than a month I could not function, spending most of my time asleep on the sofa. Eventually, once the medication was out of my system, and with love and considered care from my mother, I recovered and found myself again.

Fast forward 20 plus years, and I found myself again needing the support of mental health services, following the suicide of my first wife, followed by the loss of three pregnancies with my second wife, including a late-term stillbirth of our daughter, Danielle, and the unexpected death 18 months ago of my mother, who also took her own life.

In this experience of mental health services, I found myself, firstly, receiving therapy in a non-clinical setting, the space set up more like a room in a home, with every effort to ensure I felt comfortable and that I had the therapist's full focus. From the outset I explained my hearing challenges, and we started by taking time to position ourselves to ensure maximum eye contact and optimal speech reading. I also explained that lighting was important, so she always ensured that her room was properly lit up, even while other clients prefer a different atmosphere. We also take sessions at a slower pace, never rushed, to ensure I understand fully what she has said to me, and she in turn takes time to properly explain concepts and ideas to me in ways I can better understand. Patience, and taking time, is the key.

Because of this approach, there was no rush to medicate me, and the therapist was better equipped to support me and get to know me fully, as a person, before concluding any diagnosis or need for additional treatment.

My name is Tim Stones. I am the Chairperson of the South African Society for Mental Health and Deafness (SASMHD). I am also a user of psychosocial services, as I live with Schizoaffective Disorder, for which I am receiving treatment, and which is helping me a great deal. As such, I know I can trust my treatment team, and more happily follow and comply with their treatment plan for me.

I hope my sharing of these two hugely contrasting experiences from my journey with mental health and related services will assist those of you who work with users of mental health services to be better able to support them with efficient communication and access, and most especially to listen with your third ear, to the heart of what the person is trying to convey, understanding that what you think you have heard might not be what the deaf client meant to convey. You need to try to think and to see the world as a D/deaf or DeafBlind person does. If you can do this, your ability to appropriately and efficiently serve and treat your D/deaf and DeafBlind clients will be significantly enhanced.

My thanks once again to all who have contributed to ensuring this conference takes place. I hope you will all enjoy the contributions from our key speakers, and that this conference will be the start of relaunching SASMHD into a future that leaves a positive footprint and way forward for both mental health service providers and the Deaf and DeafBlind community.

Thank you!

## 3. WELCOME ADDRESS: PROF FUNEKA SOKUDELA HEAD OF DEPARTMENT PSYCHIATRY UNIVERSITY OF PRETORIA

Tim Stones (Chairperson SASMHD): I'm now going to introduce a very important person in our team. She has come a long way working with the deaf community, the Deaf people. She has a heart and a passion a rare love for Deaf people. She goes out of her way to find solutions, to find ways, to build bridges to inform, to educate, to inspire and ultimately to improve the quality of mental health services to the Deaf community throughout South Africa. Her name is Professor Funeka Sokudela. Prof Sokudela is a professor of forensic psychiatry. She's also the Head of the Department of Psychiatry at the University of Pretoria. I'm just going to read some of what she has done. It's such a colourful CV. She's a fellow of the Albertina Sisulu Executive Leadership Programme in Health, a Health Systems Management Programme that was created by the Universities of Pretoria, Fort Hare and the Harvard School of Health Systems and Public Health. She is a member of the South African Society of Psychiatrists and the Advocate Global Mental Health Institute. She has served in many portfolios, committees and structures. It is worth emphasising she was previously the chairperson herself of the SASMHD. She has been with us for many years. and made a considerable contribution to the sustainability and success of the SASMHD. And I am sure that she will continue to do so.

She holds several degrees, as I said, specialises in forensic psychiatry, a Master's of Medicine and a PhD in Psychiatry. She is a member of the 11th class of the Africa Leadership Initiative and South African fellow and member of the Aspen Global Leadership Network. Thank you so much, Professor Sokudela, for being with us and making the time to share your expertise and your experience with us, I now hand over the floor to you.

### WELCOME ADDRESS PROF FUNEKA SOKUDELA

*note*[1]

Well, thank you, Tim and that welcoming note is rather. It made me feel very shy, but thank you for your generosity, I'd like to thank the conference organisers and Attie for leading us to this point.

Mine is a simple job, it is just to emphasise, the relationship between SASMHD[2] and the University of Pretoria and its Department of Psychiatry. I am the current Head of the Department of Psychiatry at UP.

[1] Transcribe from the recording by Attie Smit

[2] South African Society for Mental Health and Deafness

I have been involved and part of this journey for a while, and in many different forms. My journey started with Attie and our colleague Dr Paul de Wet, the person who introduced me to mental health and deafness and he describes how he was introduced to mental health and deafness as a consultant by chair instruction, by the previous head of the Department of Psychiatry.

So that gave me the idea that sometimes we put up barriers for ourselves in terms of activating systems and sometimes those barriers are unnecessary. And so, what I bring now with my current head in terms of our relationship with mental health and deafness is the breaking of further areas. Our focus as a department has not always been on mental health and deafness services. But it has been general access for everyone, including the deaf. And we are striving to create a cohort[3] of medical or health practitioners sensitive to all the needs, especially mental health care needs, so Tim's story is touching. Thank you. Tim, as usual, you bring in a sensitive, but educational edge. It reminds us of our humanness and how we share our experiences. This is not the 1st time, colleagues, that I've listened to him sharing parts of the story. but the story evolves. So, the second picture we like. It means that even if we are not directly influencing change, our existence and sensitivity are indirectly spreading. And I think that is the role we will continue wherever we are. As a department of psychiatry and a system linked to a psychiatric hospital like the ones you described, we will continue to create that sense of sensitivity and understanding of inclusivity. From a personal account of my work, you often come across individuals referred to us simply because they are deaf. A Deaf person will be in a court. The court fails to follow what he/she is saying or explaining, and it's assumed that something is the matter. So, through our interaction with the justice system, through a program that we have been running for a while with the Justice Committee, we began to sensitise the court system to the nuances of communication, especially with people who may not be able to access services, including deaf and hearing people and the sensitivity is sipping in, not as fast as we want, but in a way that reassures us that we are dealing with an amenable system. To change is to continuously, remind, raise awareness, and persistently educate, especially practitioners who work with the public service.

As an academic department, we are glad we are part of this conversation today. It has been a difficult time in the health sector post-pandemic, but one of the thoughts was, that we wonder how people manage in the deaf community with all the havoc caused by the pandemic. Currently, in our South African context, there are many pressure points. And so that concern, where are Deaf people with mental health issues? Are they describing the story that you're

[3] A unit, division, a group

describing? Or are they telling the story of your first version of your experiences in your opening address?

And so, we as academic settings, are responsible for sensitising the population of healthcare practitioners we are raising. We enjoy the work that we do. We contribute to society. Some of them have joined now and are individuals in various sectors within the university, thanks to our transformation. For instance, you saw there was a question now about dental care, Eric asked this. And so, at any point, a deaf person contacts a healthcare practitioner - we want to ensure that the individuals raised within the University of Pretoria are sensitive and aware of getting involved with people who come from all walks of life, including deaf people. But mental health and deafness, as you know is a uniquely spaced concept of the complexity of mental health concerns by themselves. And so, the double stigma made people not reach out. These are even more important to dismantle. And so, from an academic setting becoming an important exercise. And we are taking part today, so we do not forget that duty. The recall back to duty. And Attie is a good example of how he calls people back. He has a magical way of making people work. Already I know what we will be busy doing in the next few months. So that is our involvement today as a department. But I come with colleagues from what we call the Weskoppies Chapter. Some were not joining due to connectivity issues and others due to health concerns. But that chapter, as small as it is, continues to prevail and concentrate within the hospital. But we also know that we belong to a mental health system and so, ours is to look at mental health with the notions of improving access, good quality, not just medicine, good quality services that fit the needs of the deaf. And so, it's a recommitment.

Colleagues and the Executive, thank you for giving us the space to welcome our colleagues from all fronts, and we appreciate and acknowledge DeafSA's representative, Mr Bruno Druchen CEO. We note the impressive list of speakers, and we wish them well, we are here to take it in. The organisers, we wish you well as all the guys with their gadgets in the background all the best, because it's a complex thing that we are setting up. But I know you and your team will pull it off. And so, I'd like colleagues to wish us well as we engage further today, knowing that our work is cut out for us. With those words, I'd like to hand back to you.

Tim as the Chair.

Mr Tim Stones started by saying "Thank you very much. Prof. Sokudela there's a lot there to reflect on and unpack." He goes on to express his appreciation for Prof Funeka's approach which is characterised by empathy and humanity of all people who use mental health services. Quite different from the pity approach often experienced: "don't worry I will help you" or the stigmatisation, "Don't be difficult, we know what is best for you."

He concludes by emphasising her clear vision and full commitment, which are inspiring. He conveys the appreciation of the conference.

Funeka Sokudela: Thank you.

## 4. INTRODUCTION OF CONFERENCE FACILITATOR: DR WILMA NEWHOUDT-DRUCHEN

The Chairperson introduces Dr Wilma Newhoudt-Druchen.

I would like to introduce the facilitator of the conference who doesn't need much of an introduction. Doctor Wilma Newhoudt-Druchen – how blessed we are this morning to be in the presence of remarkable people, remarkable women, impactful women who have changed the landscape of South Africa, not just the deaf community but the country in many remarkable ways.

Dr Newhoudt-Druchen most certainly has done that, breaking stereotypes, inspiring deaf people, and showing the deaf community what is possible. Your story really illustrates that in a massive way:

The Honourable Wilma Newhoudt-Druchen, a Gallaudet alumna who, in 1999, became the first deaf woman to be elected to the South African Parliament, had been selected as Gallaudet University's Visionary Leader for the month of November in recognition of her extensive advocacy efforts for both the deaf and disability communities worldwide.

A global commitment to bring fair and equitable treatment to deaf people and individuals with disabilities has been expressed through Newhoudt-Druchen's work with the World Federation of the Deaf (WFD), where she previously served as vice president. She was previously a WFD board member and president of the organising committee for the XVI WFD Congress in Durban, South Africa, in 2011. Newhoudt-Druchen strongly supports the ratification of the United Nations Convention on the Rights of Persons with Disabilities.

Newhoudt-Druchen earned a bachelor's degree in social work from Gallaudet in 1992 and a Master of Social Work degree from the University in 2005. Returning to South Africa in 1994, she put her social work and leadership skills to work for a local organisation, Deaf Community of Cape Town. She was later hired as provincial director of the Deaf Federation of South Africa (DeafSA), where she went on to serve as national chair and president. She remains active in the organisation today as a member of both the National Executive Committee and Management Committee. In 1999, she was elected to the South African Parliament on the election list of the African National Congress (ANC) after being nominated by the organisation, Disabled People South Africa. During her tenure as a member of Parliament, she has chaired the body's Joint Monitoring Committee on the Improvement of Quality of Life and Status of Children, Youth, and Disabled Persons.

Recognition Newhoudt-Druchen has received for her achievements in promoting the rights of deaf people include the WFD's Award of Merit, and an honorary doctor of laws degree from her alma mater at the 2009 Commencement, where she was the main speaker. She also was was awarded as Outstanding Young Alumnus by the Gallaudet University Alumni Association and received the Edward Miner Gallaudet Award from the Laurent Clerc Cultural Fund for improving the lives of deaf people in Africa, South Africa, and worldwide. In 2013, Gallaudet closed its lecture series in recognition of the 25th anniversary of Deaf President Now with a presentation, "International Perspectives of Human Rights," by Newhoudt-Druchen and her husband, Bruno Druchen, National Director of the DeafSA.

As a child, Newhoudt-Druchen first attended the Dominican School for the Deaf in Wittebome, Cape Town, then transferred to a girl's Catholic high school. In 1988, at the age of 24, she enrolled at Gallaudet with financial assistance for her first year from a childhood friend from the Dominican School, Lindsay Dunn, '85, who is the manager of educational programs in Gallaudet's ASL and Deaf Studies Programs. Dunn successfully fought to get her a scholarship from the United Nations Education and Training Program for Southern Africans to cover her undergraduate years at Gallaudet, and the Deaf Community of Cape Town also raised funds to cover her living expenses during the first year.

Newhoudt-Druchen speaks, with confidence, about her insights into the needs of her fellow citizens. "I am a South African, well informed about South African history and politics during the apartheid years. I did not need to work as a social worker to understand the situation of Deaf people in South Africa; I already knew their needs and problems," Newhoudt-Druchen said. "My work only makes me more aware that there is so much work to be done in the Deaf community. I am passionate about disability issues because I'm there to articulate personally what being disabled is all about."

As a member of the Parliament, Newhoudt-Druchen originally sat on two committees, the Portfolio Committee on Communications, "where I can lobby for more access for deaf and hard of hearing people to T.V. either via subtitles or sign language interpreters," said Newhoudt-Druchen explains, and the Portfolio Committee on International Relations and Co-operation. She is currently a member of the Portfolio Committee Justice and Correctional Service. "I am proud to count a leader of Ms. Newhoudt-Druchen's calibre among our alumni," said Gallaudet President T. Alan Hurwitz. "Her pioneering energy has and will continue to propel the global deaf community forward.

Ms Newhoudt-Druchen is currently a member of the Gallaudet University board of trustees.

Chairperson: Thank you, Dr. Newhouht-Druchen, for sharing your expertise and experience and making the time to facilitate this conference. We are looking forward to the process unfolding. The floor is yours.

Dr Newhoudt-Druchen - Facilitator: Thank so much Tim for this wonderful introduction and thank you Dominee (Ds) Smit. Thank you so much for the honour to facilitate today's session. I don't want to share my personal story with you, but there are 2 things that I would like to share with you. It's not specifically mental health issues. But it is as Ds. Smit announced this morning that my husband is in hospital this morning, and I would love to invite him in future to come and share with you his experience of being in the hospital that is a private hospital in this country. You know he has addressed the public hospitals. He has shared his personal experiences, and even though people laughed I think they realised how the medical system in this country must still contribute, must still learn, must still do. And this all includes the medical system. It also includes, you know, mental health, psychiatry and these services to deaf people, hard of hearing people, deaf oral, deaf people who do not use sign language, deafblind people, and all these different sectors, I think you know, as a mother also of a hearing daughter who needed to receive mental health services herself, just going into high school. I had to learn from her how the doctor spoke to her just so that she could transfer that information to me as a deaf mother, you know, and sometimes I had to wonder why God gave me this challenge, but I know now, looking back, that it was for me to be able to get that information from her so I could share with others. There is one thing that I would like to share with you. And you know, Prof. Sokudela, Tim spoke about, Tim that said: “They wanted to help”, and you know I always say, let us set aside the welfare approach. You know medical professionals need to also become more human rights approach driven, you are not there to help, as a deaf person I need to know how to help myself. And you know, for the mental health sector making use of the human rights approach is very important. So thank you for that.

Before I move on to introduce the first presenter, let me just explain.

First of all, you know you'll  see my eye gaze goes up now. My laptop is too small. So I have connected it to a television screen. You know, it's just also better for my physical health not to have t stare at my little laptop screen. So look up to a bigger screen so that I can have access to the interpreter. Anyway, before I am going to introduce the next speaker. Let me just ask that if you have any questions, please write down your questions, so that you are reminded of them at the end, when we have the discussion session you can bring up your question. So, everybody will get 20 minutes to present, then 5 minutes for a wrap-up and clarifications. Then thereafter, we will have 5 min to introduce the next speaker.

## 5. PRESENTATION MS SUSANNA KRIGE-HENDERSON (DEAF PERSON): LIVED EXPERIENCE AND RECOMMENDATIONS FOR DEAF-ACCESSIBLE MENTAL HEALTH SERVICES AND PROGRAMS

**Facilitator:** I'm now introducing you to Susanna Krige-Henderson, and I am not going to repeat her introduction, so Susanna is a deaf person who will be presenting to us this morning, and I must say that you know I applaud her because in South Africa there are so many children that struggle with maths, and my daughter is one of them. She had to go over from mathematics to math literacy. And now we have a deaf person who specialises in mathematics – she is a professor at university level. So, thank you so much, Susanna. We look forward to watching your story. Thank you.

Susanna Krige-Henderson: Thank you. I would like to share my PowerPoint presentation at this stage. Okay. I am going to present to you on the following title, and that is the lived experience and recommendations for deaf-accessible mental health services and programs.

Let me introduce myself.

**BIO**

I was born in Malawi, Africa, and am a ninth-generation citizen of South Africa. I attended the De La Bat School for the Deaf in Worcester, Western Cape, South Africa, where I passed matric with distinction. After my matric, I continued to get a certificate in Graphic Design from MacTrain College in Muizenberg, South Africa. I went to America to further study at Gallaudet University and McDaniel College and graduated from both institutions with Summa Cum Laude. I was a math lecturer at Gallaudet University for ten years.

**POWERPOINT PRESENTATION**

**1. INTRODUCTION**

- Born in Nkhoma, Malawi (1982)
- Attended the De La Bat School for the Deaf in Worcester (2000)
- Got a certificate in Graphic Design in Muizenberg (2002)
- Went to America (2003)
    - Attended Gallaudet University for a bachelor's degree in Mathematics and Secondary Education (2007)

and

    - Attended McDaniel College for a master's degree in Deaf Education (2010)

- Worked as a math lecturer at Gallaudet University for 10 years
- Medically retired (2021/2022)

***INTRODUCTION NOTES***

*I was identified as a deaf person at the age of 18 months. So I was an 18-month-old baby. when my parents found that I was deaf, it was decided by my father, who was a medical doctor, to change plans, and at the age of 4 we, as a family moved to Worcester, South Africa because my parents are originally from South Africa. From the age of 6, I started attending De la Bat School for the Deaf in Worcester, which is an Afrikaans school for deaf children. I graduated from De la Bat school in Worcester in the year 2000. For a year after that, I worked as an assistant teacher in accounting and maths and I assisted, just assisted there for a year. Then I also took up studies in graphic design. So I got a certificate in graphic design which assisted me to get entry into Gallaudet University. I finally managed to go to Gallaudet University in 2003. So, I wanted to just do graphic design. But then I realised that so many students struggle with mathematics, and I continuously had to assist them. That is when I changed careers into mathematics. So, I got a bachelor's degree in mathematics and secondary deaf education in 2007. After I graduated I went to Mcdonald College and I obtained a master's degree in 2010, to teach maths at Gallaudet University. I loved my job at Gallaudet University for 10 years. I experienced a lot of growth because I was given the opportunity to take the initiative and do things, but then, unfortunately, I was medically retired. I am a diabetic. Being a diabetic started at the age of 14. I really struggled with that as well as with mental health. Ten years later, I decided to take medical retirement, which was in 2021/2022. I decided to move back to South Africa. We have 3 children, and my children love South Africa. They want to stay here. And yeah. So that's an introduction about myself.*

## 2. EXPERIENCE

- Started attending mental health services since 2018
- Always had 100% interpreting services using Virtual Remote Interpreting (VRI) or in-person interpreters
- 3-months hospitalized in South Africa (2023)

***EXPERIENCE NOTES***

*My experiences in mental health services started in 2018 (in USA). I got a hundred per cent access in terms of sign language interpreting. And they also had virtual, remote, interpreting services (VRI) hundred per cent access in terms of sign language interpreting. So, in the whole*

*of the United States, you have VRI and the VRI is, if you can look at the picture on the screen. So, in the whole of the United States you have VRI, and the VRI is, if you can look at the picture on the screen. You will take your tablet and you click there, you make a call and you'll have an interpreter on the VRI system. The challenges are there. Because connectivity is not always very good, and doing this virtually, is not always very good. I prefer to have in-person interpreter services but as a backup, we could use the VRI.'s Wilma's husband might be sharing his experiences in the hospital. Perhaps he used VRI.*

*So, I was hospitalised for 3 months in South Africa (2023) when I had a complete blackout. I do not remember anything*.

*It was only later. when I was in the Tygerburg Hospital. Somehow my family lobbied for interpreter services to be provided. They asked for help for me in the Tygerberg Hospital. At this time, I forgot that I used to use convo, and there is a convo-app which enables people to use it to communicate with medical doctors. It's terrible that I missed that opportunity.*

## 3. RECOMMENDATIONS

- ***ConvoZA*** app downloaded on your phone
- ***Folio Intertel*** (only used for public services, not private ones): +27 82 480 0871 (Mondays to Fridays from 8:00 am to 17:00)
- ***Ananda*** Van Der Walt +27 84 677 2928
- ***Gert*** Erasmus +27 81 354 4141
- ***Magdel*** Burger +27 68 040 7731
- ***Marsanne*** Selzer +27 82 878 4732 (contact her secretary, Nanette, at +27 82 055 9993 or email at nanettevdb@sun.ac.za
- ***Michelle*** De Bruyn +27 67 777 3995
- ***Trudie*** +27 82 511 1642
- **Tali Lanesman (https://www.talilanesman.co.za/)**, Clinical Psychologist., BA degree in Psychology and SASL., Claremont, Cape Town

### *RECOMMENDATIONS NOTES*

*ConvoSA is a system that is advisable for you to use. I can recommend it. And I just wish to caution you that Convo is not magic. Convo.za, which is the local app that you can download, and there are some Afrikaans sign language interpreters as well on the convo app, so you can download the app. It is originally an American system, but it's also available in South Africa.*

*So what it is very useful for is that if you are in a room you can have your phone available to communicate. However, in the States you are not allowed to use any cell phones during treatment, so it is a very nice opportunity for us in South Africa to make use of the service since phones are not always banned, and whenever I go for treatment for my diabetics, I make use of Convo, South Africa. Website: Convo ZA – Because we understand you*

*Then there is also Folio Oline (Professional Translation & Language Services Company | Folio Online) and it is not a private service, it is only used for public services, and they have some arrangements with the government, and for government patients the services are free. However, if you go to see a private medical professional, then you have to pay for the services Folio Online provides. To discuss your simultaneous, consecutive and telephone interpreting requirements contact Liza Spies (lize.spies@folio-online.co.za) Telephone: +27 (0)21 426 2727 and the telephone numbers of interpreters on the slide. There are several interpreters, and you can see that on my slide. These are the 7 interpreters who they have available can be used for a fee.*

*Then, I would just like to show you the convo.za video, { would like to add to this, there are 61 million users in South Africa So this is important information that I wanted to share with you. So, the interpreters that they employ at Convo, they make sure that they are the best.*

*I wanted to also talk about the clinical psychologist Tali Lanesman* ***(https://www.talilanesman.co.za/),*** Clinical Psychologist. *You can see her website address here. I have not met her myself. but I really want to meet her and see whether we are able to have a conversation - what recommendations she has for mental health and deafness, you know, as a clinical psychologist, what would she suggest? She's based in Claremont, in Cape Town.*

## 4. FUTURE

- Hologram
    - Tablet
    - Watch
    - Glasses
    - Laptop

***FUTURE – NOTES***

*But when we look at the future and the possibilities that the future hold from Braam Jordaan (South African Deaf expert), he's busy making hologram technology available. Using*

*hologram technology will enable 3D images to be projected. This means that when a person signs it is accessible because you can see it from all angles. Here's an example (see picture on the left). But when we look at the future, this is a possibility using AI helping us to improve hologram technology so that it is accessible for deaf people. (#CSD Vision Film 1: The Future) YouTube: Communication service for the Deaf. Like you see in the video, for example.you can have something that you can put on your chest, which will then display the hologram image. From the start this hologram technology included mental health issues making sure that there are interpreters available for various mental health services. We're very happy to see that they are developing this material and that they are coming up with ideas on how to assist the deaf community We look forward to the possible developments in the future to assist us as the deaf community.*

*Facilitator Do you want to wrap up?*

*Presenter: Yes, I am done*

Facilitator: The questions that we have we will address at the end. So, thank you very much for your presentation. We are very excited to see how the technology will develop in the future, and how AI will assist us with this. We hope that South Africa will also be able to catch up with the international standard and the benefit that deaf kids will have from this technology, not only those in the hearing community. We know we still have a long way to go to catch up and be on the same level as other countries. Thank you very much for explaining this exciting technology to us, and sharing your personal experience with us.

Presenter: It is a pleasure.

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## 6. PRESENTATION PHILIP DOBSON, DEAFBLIND PERSON: LIVED EXPERIENCE AND RECOMMENDATIONS

Facilitator: We're going to introduce the next speaker, Philip Dobson. I saw Philip running around this morning sorting out a few things, helping everyone. We know Philip is always busy, and he never gets time to relax**.** He's always volunteering for numerous things. So, thank you very much for all your hard work and everything you do for the Deaf community. Philip is the Vice-chairperson of the SASMHD organisation. Philip has had a lot of experience working with deaf and deafblind individuals. Philip has been involved in a lot of training. So I'm handing over to you, Philip**.**

Presenter: Thank you very much.

Philip Dobson

Vice-chairperson SASMHD

**BIO**

- Born: Johannesburg. January 12, 1963. ▪ Primary School: Voorbrand Primary School Johannesburg. 1969 – 1975. ▪ High School Die Fakkel Johannesburg. 1976 – 1978.
- Further school training: Trans Orange School for the Deaf Pretoria. 1978 – 1982.
- Post-school Training:
    - Training in Banking, Administration and procedures, and controls.
    - Leadership training in the Disabled sector. (DeafSA, SANCB, DeafBlind SA, WFDB, AFDB)
    - Public liaison and awareness raising (CBA College Bloemfontein)
    - Social Science Studies – Social Competency Certificate. (Program DeafNET Centre of Knowledge)
    - ABET Adult Education Facilitators (Deaf Development Institute of South Africa)
- After School Professional Career:
    - DeafBlind SA  Banking Volkskas Bank – ABSA Bank 1983 – 1993
    - Disabled Sector: National Institute for the Deaf Worcester. Facilitator 1998 – 2013.
    - National Director DeafBlindSA 2008 – 2023.
- Sports and hobbies:

    - Comrades (10) completed, Park run-walk,
    - Volunteer service.
    - Gardening and growing vegetables.
- Vocation + Experience: Community development Actions. Social Support Services to Deaf Persons. Ministry of Word and Prayer meetings with a Small Group of Elderly Deaf persons and Small Group Workshop Spiritual Devotion. Labor Service to the Labor sector where Deaf people are employed.
- 2023 Huguenot College: Pastoral Care Diploma.
- Future: Preacher after legitimation with the calling to serve the Deaf Community and Deaf persons with Multiple Disabilities

**POWERPOINT PRESENTATION**

**SOME BACKGROUND ON PHILIP**

- Retired National Director DeafBlind SA. (DBSA) 2008 - 2023
- Facilitator and auxiliary worker, Hostel Parent at The National Institute for the Deaf Worcester (NID) 2002 - 2013
- Lifelong Community server. Various organisations.
- Lead by Example. Lead by serving.
- If I can not do it I can still learn to do it. Lifelong learning.
- Maturity comes with time
- Each day is an opportunity to learn, even if it is learning to stand up.
- Nothing comes easy but could be lost in a wink.

***SOME BACKGROUND ON PHILIP - NOTES***

*I'm very excited to be here. Can everyone see me? I can only see the people who are in front of me, so I can't see individuals who are online just confirming. The interpreter can see me. So I would like to share my lived experience as a Deaf and DeafBlind person. Let me give some background as to who I am.*

*I'm a retired National Director of DeafBlind South Africa (DBSA).*

*I was born hearing and seeing. Later I became deaf. It was quite a big change for me. It has been an interesting journey that has brought me to where I am today.*

*I worked with DBSA for many years, from 2009 onwards until 2023.*

*After the accident I had, it became a bit of a challenge to continue in this role, but I wanted to continue supporting the Deaf and DeafBlind communities. So my role changed and I became a facilitator and auxiliary worker. I've also been a lifelong community server in various organisations. I also worked with various individuals, especially within the Deaf community. I enjoy supporting the Deaf community by means of various roles that I have fulfilled and I do have quite a lot of experience and skills that I would like to share, but onto the Deaf community and the world of the DeafBlind, specifically by means of my partnership with DeafSA* in the past.

*I always believe that one needs to lead by example and you need to find solutions for problems that you face. We need to think about a way forward instead of just standing still. So I'm very excited to learn to do new things, and nothing comes easy. We understand it is a challenge, that it takes time. But I'm amazed at how things have changed in the past few years, and I'm excited to see the developments in future. So we know mental health takes a lot of time. You know. We need to be patient. It is frustrating at times. but we are all growing at our own pace, and each of us takes our own time. Every day is an opportunity for us to learn new things. Every day we need to learn to stand on our own 2 feet. We need to learn to think we need to learn to listen. We need to learn to watch in a new way. We need to adapt to the changes, we need to put the old things aside and focus on the new developments. We know nothing comes easy. We know it could all be lost in the wink of an eye. It's important for us to never give up, but to carry on with our lives.*

## (UN) FORTUNATELY

- (Un) fortunately became deaf in April 1978.
- Life as a deaf (hearing) person.
- Que Vadis? Where to…….
- Leaving my old young self behind.
- Now how does a fatherless teenage boy (15) make a new start?
- Being deaf and not able to sign.
- Being deaf and **not able** to hear for the first time.

Note >>>>>

- Then – deaf.
- Later and Now – Deaf.
- As well as VI – Visually Impaired. ( 30 )

## *(UN) FORTUNATELY – NOTES*

*The fortunate by the unfortunate. The fortunate by the unfortunate. You see, the unfortunate. The "un" part is in brackets because fortunately, I became deaf in 1978. Previously I lived my life as a hearing person. I didn't know anything about Deaf people. I did not even know there were Deaf people. The 1st deaf person I encountered was myself at the time. I was a deaf person, but deaf with a small letter D because I was not able to sign. I did not understand deaf culture. I did not understand what it meant to be a deaf person with Deaf being the capital D. I'd never heard of sign language, never seen sign language before. I later realised I*

*needed to leave my hearing life behind and embrace my deafness. At 15 years of age, I as a teenage boy realised I needed to make a new start. My father had passed away previously. So, it was. My Mom was blind and myself at the age of 15. I needed to make a new start. But how? How does one do that? There's no guidance. How does one do that if there's no support? At that time I was only deaf. I did not know any Sign Language, yet I'd never even heard of Sign Language. I did not know where to go. I did not know where I fit in. I felt completely lost. I'd not set foot in the deaf world. I had not been part of the deaf community at that stage. It was a very difficult time in my life – unfortunately but also, fortunately to explain initially I was deaf with a small letter d, I had not yet been part of the deaf community. I did not know anything about sign language or deaf culture. Now I am proud to be Deaf. Capital, D Deaf, because I'm part of the Deaf community. I understand Deaf culture as well as a visually impaired person at the age of 30. I will explain each of these points in detail a bit.*

### FORTUNATELY

- I then had to attend a school far away.
- Had to adapt to stay in a hostel. Amongst my new peers who spoke Sign Language.
- Adapt to a new…….
- How?
- That is where Mental Health and Deafness started in my life.
- The road to becoming….
- How? Who ? Where? When?
- Psychology therapy.
- By Name: Dr Elsabé Smuts Pauw. ( Late )
- At Transoranje School for Deaf.
- October 1978.

**THERAPY TO ……**

deaf → Deaf

With Guidance

With support

I am….

***FORTUNATELY - NOTES***

*The "fortunately" part. Fortunately, at that time I moved to a deaf school. The school was far away from my home. As I stayed in Johannesburg, then I attended school in Pretoria, at Transoranje School for the Deaf, which meant I had to stay at a hostel. I was amongst my own peers who are also deaf, who signed. But I did not know Sign Language it was completely new to me at that time I had to adapt to a new environment I had to learn how to deal with this new change in my life to find a new way. But how?*

*That time is where mental health and deafness started in my life - the journey on the road to becoming started at that stage. I needed to figure out how, who, where? All these questions I needed to ask. I needed assistance from professionals, psychologists, and therapy at that stage. One person who had a tremendous impact on my life whom I cannot thank enough for all the things that she has done for me in my life Dr. Elsabe Smuts-Pauw, who, unfortunately, passed away. Fortunately, previously she attended the mental health and Deafness conference that we had in Worcester, and she touched the lives of many Deaf individuals.*

*She was a psychologist at Transoranje School for the Deaf from October of 1978 when I was a learner at the school. That's where my mental health and deafness journey started because I started receiving my 1st ever support from a mental health professional. Dr Elsabe Smuts-Pauw was aware of the challenges that Deaf individuals face and the fact that they need professional support.*

*She understood what it meant to start as a small letter d/deaf, and then later transitioned to becoming part of the Deaf community and the Deaf world as a hearing person. To then become a Deaf individual, she understood the challenges involved in this, quite a challenge, and she yeah, she gave so much advice. To us in this transition from a small letter d to a capital D of being Deaf. In that guidance, she made sure she was there to support us and care for us, and to make sure that with the knowledge that she had she never tried to force it onto us. And so yeah, to make sure that we can understand the journey that we were on and yes, to put back that old life of us and focus on the future. Yes, in that transition of being a small letter, "d" deaf*

*person, and then becoming a Culturally Deaf person with confidence, involves confidence. And to make sure that you understand that identity of being Deaf for I can accept who I am, and that I'm happy to be a Deaf person. And yes, I'm a Deaf person. I identify as a Deaf person and am satisfied with who I am.*

**ANOTHER (UN) FORTUNATE EVENT**

As life progresses…

- 3 May 1993
- Deaf > DeafBlind

Yet again….

- Psychologist and therapy.
- By Name: Dr Elsabé Smuts Pauw. (Late)

***ANOTHER ( UN ) FORTUNATE EVENT – NOTES***

***As life progresses…***

*On the 3rd of May, 1993, I became deafblind. and transitioned into another phase. Yes, again I can say, (un) fortunate because it was a "fortunate" event. Again, psychotherapy by Dr. Elsabe Smuts-Pauw -* ***to transition from a Deaf person to a DeafBlind person.*** *But yet again at that time, it wasn't easy. It was very difficult for me.* ***But*** *I had a person to go to and then again to assist me mentally. It was Dr. Elsabe Smuts-Pauw who counselled me in that transition phase, and she was there to advise me and guide me.*

**NEW PROFESSION IN WORCESTER**

- Working in a Therapeutic Deaf Friendly environment. All where MHD started in 2004.
- Rev AL Smit.
- Always room to learn new things and grow.
- 2007 European Mental Health and Deafness Congress Haarlem. The Netherlands.
- Join forces.

***NEW PROFESSION IN WORCESTER – N0TES***

*And with that advice, I was living in Pretoria, I moved to Worcester to start a new life, and that would be new as well. She (Dr Smuts-Pauw) worked closely and collaborated with the*

*Worcester colleagues, and she knew exactly where to put me, and then also made sure that I got deaf-friendly therapy. And yeah, that helped me tremendously. and the support also assisted me and the environment that I was in, and the services that surrounded me also helped me, and that was very important mental health support. And it started with the Mental Health and Deafness Conference that was hosted in 2004, with Ds At Smit. and who also advised me. And how and it's the same conference that we're having now. Hermie (social worker at Lewensruimte for the Deaf) also advised me on mental health issues, and how I can deal with them. And always to have room to learn new things and to grow. But at that time it gives us more time to grow, and to allow ourselves to adapt to your circumstances and your situation, not that the situations define you, but to grow from that, and always be in that situation where you can grow from. Yes, and then also to understand who you are in that situation in 2007, at the European Mental Health and Deafness Congress in the Netherlands. We've learned a lot and through that, I've grown. And then to accept that this is the environment that we are living in as Deaf people and DeafBlind people - and then the mental health support. And to come to accept that and that we can join forces as Mental Health and Deafness and DeafBlindness- people, That's what I've learned there as I get involved at NID. And there was also a lot of capacity. That helped me to work in different environments to be able to support Deaf people, to support one another, with different disabilities, and to learn from other persons in the Deaf environment with different disabilities.*

**CAPACITATED NATIONAL DIRECTOR DEAFBLIND SOUTH AFRICA (DBSA)**

- New partnerships.
- New ventures.
- Building and expanding a community.
- Each one with dignity.

But…..

- Being deaf
- Being DeafBlind
- Special needs to access COMMUNICATION!

***CAPACITATED NATIONAL DIRECTOR DEAFBLIND SOUTH AFRICA (DBSA) – NOTES***

*New partnerships and new ventures were formed. and building and expanding a community with each one with that human dignity that we could have. and that was very important for us. At the time I was put in DeafBlind South Africa, where I established rebuilding, who assisted*

*me? It was At Smit who assisted me and supported me in terms of my mental health issues and then also to respect one another, to respect other people with disabilities, and also persons with deafblindness, and also persons with other disabilities that are deaf, and also to guide us. Through that knowledge, we share and then create an environment where we can support one another. We must do that.*

**THE LACK OF ACCESSIBLE MENTAL HEALTH SERVICES**

BECOMES

- Dreams of denial.
- A nightmare for the dignity of persons with COMMUNICATION BARRIERS.

BECAUSE:

- The status of Mental Health organisations.
- Exclusion of stakeholders who are d/Deaf and d/DeafBlind.
- Mainstreaming is exclusion.
- Not catering to the most left behind in an inclusive environment!
- Use the Blessing of – SASMHD.
- Go back to the archives.
- Look at the 2004 Africa Workshop on MHD and the 2005 MHD World Congress both hosted in Worcester South Africa - Resolutions.

***THE LACK OF ACCESSIBLE MENTAL HEALTH SERVICES - NOTES***

*But as the National Director of DeafBlind South Africa, it wasn't easy at all. As I worked in my position there were so many barriers and challenges we faced in South Africa. We had the people, deaf people with a small d and deaf people with a capital D, the people that are culturally deaf. Then we also had DeafBlind people. People don't know how to communicate with us, and to make sure that our mental health issues are being addressed. In addition, some of them had cancer, and some of them became instantly deafblind. How to assist them through/in that transition phase. There is little support for them after they leave school. So they came to us as DeafBlindSA, and we had to help them, and we couldn't transition them to Worcester. In South Africa, they are scattered over large and remote areas in the 9 provinces where they had to be assisted, with little or no access to mental health services. So, they needed to know where to get access to services to know where they could have access to communicate with people who would understand their needs. I'm happy to see that Susan has shared with us this new development and the communication strategies that are there to bring access to Deaf people. But DeafBlind people? What is the access for us? So, we need to*

*make sure that mental health services are accessible for D/deaf and DeafBlind people and Hard-of-Hearing people. So we need to make sure that mental health services are accessible for D/deaf, DeafBlind and Hard-of-Hearing people is not just a dream.*

*There's a dream of denial. People do not accept who they are. So, there's no space for them to grow, for dignity as a person. Then it becomes a nightmare. When will the world in South Africa change for the better for DeafBlind, D/deaf and Hard-of-Hearing people as well? The exclusion of stakeholders who are D/deaf, DeafBlind and Hard-of-Hearing. Mainstreaming is exclusion and not catering for the most left behind. In an "inclusive" environment the D/deaf, DeafBlind and Hard-of-Hearing community they are excluded. Yes, there's an organisation. But there are other organisations abroad that are doing wonderful work. and they're working with government, but not here in South Africa. The networking is extremely weak. But in the mainstream, in the inclusive mainstream, they are excluded. We are extremely left behind. And really is the inclusivity for us as DeafBlind people? Mental health is the buzzword of the year, and we are celebrating a mental health awareness month. But the environment is not conducive for us here in South Africa. Not accessible like it is in many places aboard. But here in South Africa. We don't see that networking. Yes, we have a mental organisation here, but Deaf people are not part of that organisation, and DeafBlind people are either for organisations, for mental health. So we need D/deaf people and DeafBlind people not to be excluded. And that's been a huge concern for me. Who is to blame? We continue pointing finger. But we need to look for the blessings, and the blessing is that South Africa has the South African Society for Mental and Deafness (SASMHD). But funds are needed. The passion is there, and Ds Smit is still here with us for ages, has been here for us, and supporting Mental Health and Deafness, and deaf issues. Why, this is why we have this conference today because of Ds At. But if you take a look at the 2005 World Conference hosted here at Worcester. If you take a look at the 2004 Africa Workshop on Mental Health and Deafness hosted here at Worcester. If you look at the resolutions, we need to look at those resolutions that were taken at those two conferences, and maybe let's dust off the dust on those resolutions. So it says that we need to rapidly improve this. The passion was there but it has subsided, and nobody was really interested in taking those resolutions forward. If we look at those resolutions that were taken it stays the same but the world around us does. No, it's never too late to start. We need to hold mental health institutions and organisations accountable and for us to adapt. Yes, we can take those resolutions, but we need the world around us also to adapt. We need to vent, and we need to tell people, and we need ourselves to be accountable.*

*What will be the way forward for Mental Health and Deafness? Yes, many people are old and still with us, but we need to form new relationships. and then we need to get new leadership to take up the baton and then to take up the spear like Wilma said it's a basic human right.*

*And how are we going to meet that basic human right of people? So, I can continue with my speech. But I think I'm done. Thank you to everyone who has been involved, like Ds. At has always been with us and everyone else has been with us for many years and, like the late Dr. Elsabe Smuts-Pauw that's been with us. We started with the process and Dr. Paul De Wet who started with that whole process as well, and we need people to take our hands and to continue with this and to lobby for mental health services for D/deaf and DeafBlind people. Thank you.*

Love you

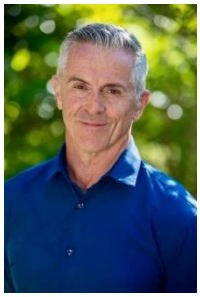
**Facilitator:** Philip, thank you so much for your presentation and I've made some notes. What you just shared with us and unfortunately become fortunate and yourself became the advocate for your own mental health rights unfortunately becoming fortunate. Fortunately, because you are the advocate for your own rights, and we all need to be the advocates and the activist for our own right rights. Yes, in 2004 we had that conference. That's 20 years ago. Many at that time and medical professions they retired. Maybe they're not here today with us, and the young medical professions that we do have with us. They need to know what was said in 2004. And what were these resolutions? So, let's add that to our discussions. Let's blow off the dust of those resolutions. And let's look at those resolutions and put them together with the conference resolutions of today. Then we take those matters forward. Yes, at the conference and it was said, let us join forces. Are we doing that? Are we? Are we joining forces? Or are we working in silos? That's the question that we need to answer. And because working in silos is a waste of time and we need to join forces to address this, especially the Deaf, the DeafBlind, the Deafened and Hard-of-Hearing communities. Thank you, Philip Thank you. Can you just hold your questions for Philip Till we had our last speaker?

## 7. PRESENTATION DR. MURDOCK HENDERSON: DEAF-SPECIFIC ISSUES IN MENTAL HEALTH CARE FOR DEAF PERSONS – THE FULL EXPLORATION OF DEAF CENTRALIZED MENTAL HEALTH SERVICES IN SOUTH AFRICA

**Facilitator:** The next speaker is Dr. Murdock Henderson, he is Deaf and a clinical psychologist from the USA. He and Mrs Susanna Krige-Henderson and their children are currently in South Africa. He will introduce himself and continue with his presentation, thank you so much, and I give over to you.

**Presenter:** Thank you, Wilma

**BIO**



Dr. Murdock Henderson, Clinical Psychologist, President of PEAK*, Inc, Worked in clinical settings for 20+ years, Former professor and clinical researcher, Actively involved with mental health in RSA for 7+ years. Doctorate in Clinical Psychology, Internship at University of Miami Medical School. Fellowship at

Harvard Medical School *Promoting the Educational and Advocacy rights for Kids (especially those with challenges)

**Deaf-specific Issues in Mental Health Care for Deaf Persons**

SASMHD ExcPlus Conference 18-10-2024

Dr. Murdock Henderson

Clinical Psychology

Mental health as we see this term in today's literature and society is fragmentalised, stigmatised, and in return incomplete, incoherent, and spoken as if a taboo topic, especially in the Deaf, Hard of Hearing, and DeafBlind communities of South Africa. When I first came to South Africa in 2007, I met many of the same leaders who are present at this morning's conference: Mr. Bruno and Dr. Wilma Druchen, Mr. Mohamed Jabaar, Mr. Philip Dobson, Mrs. Susanna Krige-Henderson, and Rev. Attie Smit.

As a matter of fact, Rev. Smit was one of the pioneers who set up the World Mental Health Conference for the Deaf in 2005. A plaque from that memorable moment proudly stands at the front entrance of the main headquarters on the property of the National Institute for the Deaf (NID).

However, back in 2009, a group of us set up a NGO called the Intaba to try to spearhead a number of projects to close the gap between providing quality mental health services to

the DHH/DB communities in the Western Cape. These efforts were strictly pro-bono based, and the efforts have been stifled for a number of reasons that have carried over today from 20 years ago. The NGO folded in 2017.

The testimonies from Mrs Henderson and Mr Dobson this morning are only two of dozens and dozens of DHH/DB persons who have gone through similar experiences themselves while seeking help in a mental health capacity here in the western province. It is unfortunately dismal, to say the least, and I have been asked to pinpoint some of the specific issues pertaining to this sub-population and how we can move forward with a model that Rev. Jan Oberholzer will expand upon following my presentation.

Key issues at hand are:

1. Deaf-friendly and Deaf-accessible services. Creating a safe space where DHH/DB patrons can go to seek professional mental health services.
2. Professional interpretation: Ensuring that a professional (preferably certified in mental health interpreting) interpreter is present from the very beginning of the intake process to discharge, as well as all follow-up appointments. These services are to be paid for by a governmental office such as the Department of Health.
3. Accredited mental health facilities: Training key personnel in identified mental health clinics that are within a certain proximity of where high percentages of DHH/DB people live so that when individuals come in from these areas seeking professional help, they are not met by unprofessional “silent” treatment. A key issue is who will lead these trainings and who will pay for these services. Once these locations have been established, they will be placed on the website so that DHH/DB and their families can locate these facilities with relative ease.
4. Electronic facilitation: Creating a website in which these identified mental health clinics have been established within larger medical complexes (e.g., Tyger Hospital, Paarl Mental Health). This website will also have important information in not only written English, Afrikaans, and Xhosa, but also South African Sign Language (SASL), Afrikaans Sign Language (AfSL*) - not to be mistaken with American Sign Language (ASL), and a few others (if an interpreter or skilled professional is not available in those sign languages).
5. Medical and Social Work programs: Offering workshops or seminars in the different medical and social work programs throughout Western Cape with a major tenet being that of targeting students that are most likely to find themselves in settings where DHH/DB are likely to end up going as well for a variety of different medical and mental health services.

***Transcription of the voice-over of Dr Henderson ASL presentation**:*

*Thank you. Wilma for that introduction. And it's really appreciative to watch everyone, watch the mental health year in South Africa and the developments. And then, since it's now 20 years since I've joined in 2003 and tried to set up, an independent NGO. But unfortunately, that time it wasn't there. and it wasn't very specifically for the deaf, hard of hearing and deafblind people in South Africa. My wife, Susan Henderson grew up here in South Africa and it wasn't very specifically for the deaf, hard of hearing and deafblind people in South Africa. Thank you for inviting me to be part of this conference to have these kinds of discussions. And I'll we going to really look at this in and that we can. And I agree that we can. How are we going to join forces in making sure that we can address those issues in front of us - and that we can? So, I would definitely like to share my presentation as well. We all know the issues right? What Wilma also said is that we will need to go back to people like Philip has said that people are going to retire, and people are coming together, new faces that are not familiar with deafblind issues in the mental health scenario, so that we've need to understand the full exploration of deaf centralized mental health services in South Africa today. I will be focusing on 5 key points across all domains of deaf. That we can make sure that we can focus on those 5 and deaf accessibility.*

*1. Deaf-accessible, and deaf-friendly services the same, or is there a difference?*

*And the 1st step that we need to go into is mental health.*

*The setting or situation, be it a consultation, consultation room, hospital, clinic, emergency at home or in public, of the first or subsequent exposure to mental health services should be marked by the creation of a safe atmosphere, empathy, respect, unconditional positive acceptance, non- stigmatisation, impartiality and expertise taking into account communication barriers associated with deafness, hard-of-hearing or deafblindness in a hearing environment.*

*You know this is very important. This topic is very important and very powerful, extremely powerful, to have a safe space. And I wonder if you know what creating a safe space means. You know, if a child is born into the world, you know you are taken or the woman who's pregnant is rushed to the hospital sometimes in an ambulance, and then she's taken to a safe space to have her baby, and really what we require is to have a safe when deaf persons are finding themselves in a situation where they are not mentally okay, that they be taken to a safe space where they can be looked after by professionals in a safe space. and where the professionals can look at them and investigate. So, 1st of all, you need to go for screening to establish what is the best treatment plan for you. And so, patients who are deaf, hard-*

*of-hearing, deafblind and having mental difficulties, they should and sometimes we need to take a look and see when you have had an experience, you need to see that there must be a good strategy. Families must be aware of what to do. The patient must know what their rights are. They must know where they can get their medication. They must understand why they're receiving the medication and the reasons for the medication to be provided. So that is the 1st part of the model, and then the second part.*

*2. Professional interpretation services*

*The thing is that you can have professional interpreter services and sometimes it's okay to use friends. Then you can also have a deaf hard of hearing family member that interpret for deaf people. But this*

*is not always appropriate. It is appropriate to use professional interpreting services. It's not the best scenario to have a family member interpret for another family member. It is important to have a professional sign language interpreter to get the most successful outcomes.*

*Those are the 2 things my wife face with an issue of who will be paying for the services, she just sat there waiting. There was no recommendation who knew who would pay for the professional interpreter services, etcetera, and I think we need to come to an agreement of who will pay for the services. You know I suspect that now that South African Sign Language is an official language, I don't know. Maybe Wilma can correct me if I'm wrong. But perhaps the Department of Health, with the recognition of South African Sign Language as an official language. Perhaps the Department of Health should be responsible for paying for these services?*

*3. Accredited mental health facilities.*

*This is a very proactive part of the model. And it is very important that, and perhaps you can read the slide. What the slide says is that it is very important for us to identify mental health hospitals and clinics in the proximity where a high percentage of DHH/DB people live deaf or deafblind as well as hard of hearing. Individuals go when they are faced with mental health difficulties, you know, if perhaps we can establish services in an area where there are many deaf people concentrated. There could be many*

*deaf people that live in the Worcester area, and so, if we can have accredited mental health facilities that can provide services.*

*You know, I think, in Bellville, or even in Cape Town, perhaps in Durbanville we should have key centres* where we can have persons who are specially trained to provide services for deaf people. I think we *need to identify these medical health or mental health facilities that can be identified and therefore trained so that we can be in a position to provide services. What is*

*important also is that we should continuously train these accredited mental health facilities so that they can be updated and know how to provide services. And perhaps we can't do it today. But I do think we need to identify those leaders who are qualified to provide training on-site to assist these hearing people, to know how to partner and work with Deaf leaders who are qualified to provide training on-site to assist these hearing people, to know how to partner and work with deaf persons to provide services*

*4. Full electronic facilitation*

*We need to identify, we need to develop and we need to create and set up systems under point number*

*So a website that is fully accessible electronically, whether that be via laptop tablet cell phone, any other device that can support the work of this organisation that maybe Wilma or Bruno can assist us, you know, to see where we can find funding to create a website which can then become our hub. If you want to call it that a hub for the deaf community to access services you know, if they see that they have a friend who is really depressed, they can go into the website and find information. Perhaps we can have a live virtual map that will indicate where deaf people can access services that are available for them and accessible places. Perhaps, like Tygerburg Hospital, the Paarl General Hospital, and Worcester Hospital. Maybe we can just make sure that we recognise these and identify these centres. We sensitise the people. We provide training with those people, so that when deaf persons come into those facilities for services. You know, they can access it by going into the website and that perhaps this website will have important information available not only in the written language, but also in other signed languages whatever that is because in the Worcester area, they use Afrikaans sign language and in other parts, like Johannesburg, they use a different dialect, and I think we need to be able to make services accessible to the whole deaf community in South Africa. Then the last point, the number*

*5. Medical and Social Work Degree Programs*

*This point I would like to discuss has to do with training, medical and social work degree programs, they should offer seminars, maybe Stellenbosch University or other institutions of higher learning. Let us work with them so that they can provide proper training. ……*

*……...*

*……*

*……*

*In the United States, at the University of Utah that is part of my job. I go to various departments within that university. I go to the dentistry department. I go to the Mental Health Department,*

*to the medical professionals, and I even go to the surgery department to sensitise individuals there, so that they can learn and see. They can even perhaps, pick up a couple of signs. I mean, mostly they don't. But at least you create an awareness. And you know, in the States we use 911. I think you use 10111 in South Africa. When a doctor approaches you or any medical staff come to you, or a social worker, if they see that you are a deaf person, they are already sensitised and know that you, as a deaf person have specific rights. We have to become more proactive in our search to find more accessible and deaf-friendly mental health care services in South Africa. So that is my presentation. I wish to thank you so much for your time. I appreciate it.*

Facilitator: Thank you so much Dr Henderson for your presentation. I think in the interim there are possibilities of certain things that can be done, deaf-friendly and deaf-accessible safe spaces we can create. We need to look at how we can join forces with services that are already available. Of course, South Africa is vast and services are limited, Deaf people also don't live in a specific geographical area. We need to make sure that we make use of e.g. DeafSA Regional Offices we have in various regions where they have Social Auxiliary Workers who are mostly Deaf individuals, especially in the regional offices. What I am concerned about is that Folio potentially might close down. Some questions are being asked of Folio because they are very good e.g. of how in hospitals and clinics interpreter services can be provided and think of another way for both private and medical institutions to work with the Deaf Federation of South Africa to provide interpreters. However, private institutions don't always want people to know of a Deaf patient in their institution because it may cause a stigma for the patient. Mental health carries a stigma in South Africa, especially after Covid. Mental health care services are necessary in this country, and as said previously, in Schools for the Deaf. May persons know who can be contacted in case there is a need for mental health care services. We need to just create and spread more awareness. And you know, during Deaf Awareness Month they almost spoke nothing about mental health care services. And it is like Philip said in October it's mental health month. In the various articles in newspapers, very little was said about Deaf people. And you know social media is a very powerful platform that reaches many people. Twitter (X), Tiktok, Facebook, Instagram. They are all amazing in spreading news and information. Is this done for Deaf people? Not always so.

Thank you so much, Dr Murdock Henderson. Much appreciate your presentation.

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## 8. PRESENTATION REV.DR. JAN OBERHOLZER: COLLABORATION WITH HEALTH AND MENTAL HEALTH PROFESSIONALS AND WORKERS, HOSPITALS AND CLINICS, PRIMARY, SECONDARY AND TERTIARY CARE

Facilitator: Our next speaker is Rev/Dr Jan Obeholzer from the De la Bat Deaf Church in Bellville. He is going to speak on the collaboration with mental health professionals and workers in hospitals, clinics, primary, secondary and tertiary care levels. I am handing over to you, Domi Jan. We look forward to your presentation.

**BIO**

Jan studied Theology and was legitimised on 20 November 1987. Jan obtained a PhD degree in theology at the University of Stellenbosch. He was head of the Deaf Christian Ministry Africa (DCMA) College in Worcester, where, since 2006, 14 culturally Deaf pastors have been trained for ministry. They all serve as pastors in Eswatini, Zimbabwe, Malawi, Zambia, and Ghana. Currently (2024), Jan is the pastor at the De La Bat-Bellville Church of Deaf people. *Soli Deo Gloria.*

SASMHD
SOUTH AFRICAN SOCIETY FOR MENTAL HEALTH & DEAFNESS
NPO registration: 164-239 NPO

*Promoting the mental health and wellbeing of Deaf and DeafBlind persons and their families*

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**SOUTH AFRICAN SOCIETY FOR MENTAL HEALTH AND DEAFNESS (SASMHD)**

❖

**INVITATION TO JOIN THE SASMHD EXCO PLUS CONFERENCE ON DEAF- AND DEAFBLIND-FRIENDLY MENTAL HEALTH SERVICES IN COLLABORATION WITH THE UNIVERSITY PRETORIA AND THE UNIVERSITY STELLENBOSCH SOUTH AFRICAN SOCIETY FOR MENTAL HEALTH AND DEAFNESS**

***A new initiative for Deaf- and DeafBlind- friendly Mental Health programs and services at primary, secondary and tertiary levels has commenced in collaboration with academic departments and mental health professionals. This initiative aims to engage all relevant parties to join the outreach to D/deaf and DeafBlind communities, schools, vulnerable persons, and families who may benefit from having access to mental health programs and services at primary, secondary, and tertiary levels to enjoy optimal health and wellbeing***

**THE THEME: Collaboration with health and mental health professionals and workers, hospitals and clinics, primary, secondary and tertiary care.**

**INTRODUCTION**

According to the 2021 *American Community Survey (ACS),* about 3.6% of the U.S. population, or about 11 million individuals, consider themselves deaf or have serious difficulty hearing.

Losing your ability to hear can dramatically impact the way you interact with others and experience life. It can also put you at greater risk for developing mental health disorders such as anxiety and depression.

Furthermore, the risk is that some Deaf persons are often misdiagnosed, which results in inappropriate treatment. Communication difficulties often lead to the incorrect use of medication. Lack of Deaf friendly information contributes to years of suffering of Deaf persons from conditions that can be treated effectively over a short period of time.

Psychiatrists and psychologists specialising in mental health and deafness identified several Deaf-specific concerns mental health professionals should be aware of when diagnosing and prescribing treatment.

A research study done by the National Institute for Mental Health in England, *Mental Health and Deafness, Towards Equity and Access, Best Practice Guidance,* 2002, provided me much useful information towards finding an answer to the presentation theme, namely, ***"Collaboration with health and mental health professionals and workers, hospitals and clinics, primary, secondary and tertiary care".*** Let's start our presentation with our context.

**1. A VUCA-WORLD**

We live in a **VUCA**-world. The world we live in has changed, enormously as of late. VUCA is an acronym for the following: *Volatile, Uncertain, Complex and Ambiguous.*

Living currently as individuals, within families, communities and a country, we are faced with huge challenges, daily.

Deaf[4]- and DeafBlind persons' challenges are intensified. Deaf persons face enormous communication barriers, especially in terms of access to mental health care- and services. Deaf persons need a communication facilitator, and DeafBlind persons need both a communication facilitator (interpreter) as well as a guide (movement). Let's look at Deafness and Deaf culture.

[4] We will use the convention 'Deaf' for those who are born Deaf and see themselves as part of a Deaf community and 'deaf' for those who have acquired deafness and mainly use oral means of communication.

## 2. DEAFNESS AND CULTURE

Most people think of Deafness as a disability. That view is often shared by those who acquire deafness through illness or injury. However, many people who are born Deaf and who communicate mainly through Sign Language see themselves as part of a distinct community with a common language and cultural heritage. Sign Language should not be seen as a degraded form of any spoken language. Rather, it is a fully formed language in its own right - readily capable of drama, comedy, poetry and the most evolved forms of prose. It should be remembered, also, that many users of Sign Language will view English, including written English, as, at best, a second language. It needs also to be born in mind that most Deaf school leavers will only reach a reading age of nine. Written communication of complex issues will, therefore, often be insufficient. What about DeafBlindness?

## 3. DEAFBLINDNESS AND CULTURE

DeafBlind is an umbrella term that covers a few different groups. The group with the greatest affinity to the Deaf community are those born both deaf and blind, but others acquire one sensory impairment later than the other and have different communication skills and needs.

This is a very small population and widely dispersed. Very little is known about mental health problems and treatment in this group although some do access the specialist Deaf services. People who are born deafblind may exhibit unusual behaviour, including self-harm and destructiveness, to communicate.

The emotional impact of DeafBlindness[5] can vary greatly from person to person, however, it is generally true that many Deafblind people have challenges accessing information, communicating and socialising, which can have an impact on their emotional and mental well-being. DeafBlindness is a rare condition in which an individual has combined hearing and vision loss, thus limiting access to both auditory and visual information. There are many causes of DeafBlindness including illness, accident, genetic syndrome or the process of aging.

Among the greatest difficulties DeafBlind people face are those related to communication and mobility; communication barriers can lead to a profound sense of *isolation* and *loneliness*. DeafBlind people can and do hold responsible jobs in challenging fields, but job opportunities remain limited[6].

Living with DeafBlindness does not always have a significant impact on your independence. Some people go about their daily lives with just a few minor adjustments or some well-planned technology. Others will need more support, such as a communicator guide or support worker,

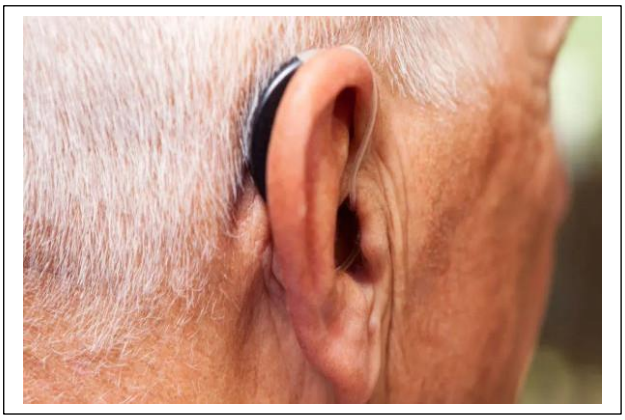
[5] See the following link: https://thesignsoflife.com.au/deafblindness-mental-health/.

[6] See the following link: https://www.ncdhhs.gov/documents/files/facts-about-deaf-blind-people/open.

to help them with everyday tasks. The question may be asked, are there a link between mental ill health and deafness?

## 4. MENTAL HEALTH AND DEAFNESS

There is a link between mental ill health and deafness[7]. Estimates in children suggest a prevalence of mental health problems of 40% in Deaf children compared to 25% in their hearing counterparts.



In adults, several studies from different countries have indicated a significantly higher level of mental ill health. Alcohol problems are frequently mentioned, although much of the evidence for this is anecdotal. This link is not entirely surprising.

- *Firstly*, some forms of deafness are caused by damage to the brain before birth. It would be remarkable if this did not, on some occasions at least, give rise to other difficulties.
- *Secondly*, Deafness for many people is associated with social exclusion and reduced educational and employment opportunities. The links with this and mental health status are well known and documented, most recently in the report from the *Social Exclusion Unit Mental Health* and *Social Exclusion*.

In fact, hearing loss and depression in older adults go hand in hand. Statistics have it that there is a link between mental ill health and deafness. Loss of hearing is a common complaint among older adults, whether it's caused by genetics, noise, illness, or age.

According to the *National Institute on Aging*, approximately one in three people between the ages of 65 and 74 suffers from hearing loss.

Losing your ability to hear can dramatically impact the way you interact with others and experience life. It can also put you at greater risk for developing *mental health disorders* such as anxiety and depression.

[7] See the following link: http://www.socialexclusion.gov.uk.

In fact, hearing loss and depression in older adults go hand in hand. One study showed that older adults with deafness were 47% more likely to experience depression symptoms. For those who already have mental health issues, hearing loss can worsen the problem.

The precise figures can be, and are, debated but there is no doubt that there is a higher incidence of mental health problems among Deaf people when compared to the hearing population. This has a clear implication for mental health services, and it needs to be remembered that working with Deaf people takes considerably longer than with hearing individuals, so the necessary investment in services can be commensurately greater.

There is a need to establish the true extent of need on a local basis to inform planning and provision. This will best be done by local collaborations between health and social services who share a responsibility for this group of people. Given the size of the population, there may be economies in carrying this out over a large area, such as the size of a Strategic Health Authority. Do health professional have awareness of the needs of Deaf persons?

## 5. DEAF AWARENESS

Many health service staff have **little awareness** of the needs of Deaf persons and the culture they inhabit. This is not to make a criticism but reflects the smallish population that they are likely to encounter during their working lives. The government has given a clear commitment to reducing inequalities and to improve access to effective health and social care services for everyone *(National Standards, Local Action – Health and Social Care Standards and Planning Framework, 2004*)[8]. The introduction of Deaf awareness training (which currently happens in some health settings) would go some way to achieving this. How does hearing and mental health link up?

## 6. HEARING AND MENTAL HEALTH

Hearing and speech are vital to our **ability to communicate** with other people through language. Free-flowing communication allows us to build fulfilling relationships and enjoy a vibrant life experience; it's an essential part of being human.

How does a hearing impairment affect you emotionally? Deafness—whether mild, moderate, or total—interferes with our ability to communicate and socialize. It affects the quality of our interactions with other people, whether we're trying to understand someone on the phone or order a meal in a restaurant. Losing the ability to hear and interpret things clearly can make a person feel separate from the rest of the world. What are the psychological effects of hearing loss?

[8] See the following: http://www.dh.gov.uk.

## 7. PSYCHOLOGICAL EFFECTS AND HEARING LOSS

articipating in everyday casual banter is not easy for those who don't hear well. The individual might feel shame, awkwardness, and inadequacy because they're not able to understand others or keep up with the discussion. The inability to hear clearly can cause disorientation, leading the person to behave in socially unacceptable ways such as speaking out of turn—and this only heightens their embarrassment. Some might even experience paranoia and believe that others are talking about them.

For seniors who struggle to hear every day, the mental exhaustion can cause them to simply give up. They might eventually start skipping birthday parties, dinners, holiday gatherings, and other events where large groups of people gather in noisy settings. While this self-imposed reclusiveness may seem easier, over time it can make the person socially isolated, lonely, and depressed. They may feel like an outlier within their own families and social groups—an observer in life rather than an active participant.

Below are some other important ways in which hearing loss can influence mental health:

- Adults with hearing loss may become anxious about missing phone calls and alarms. They may worry about mishearing what others are saying to them or feel guilty about misunderstandings.

**8.** The social exclusion and loneliness linked with hearing loss can predispose people to schizophrenia. This is thought to be caused by increased dopamine sensitivity. How does hearing loss affect the brain?

## 9. HOW DOES HEARING LOSS AFFECT THE BRAIN?

The task of processing the sounds we hear helps our brain stay active. When you lose some or all your hearing, the part of your brain that performs this task can atrophy (deteriorate). This can cause cognitive decline, which includes symptoms such as difficulty thinking and concentrating. Since hearing loss affects balance, it can cause avoidance of physical activity, which in turn may lead to depression.

People who hear normally often assume that speaking loudly and repeating words is an appropriate response to an older adult with deafness. However, this behaviour reinforces misconceptions that seniors with hearing loss are "slow." Internalizing this notion can intensify the emotional distress of losing one's hearing. Losing the ability to hear represents a significant loss. And like with any loss, it's often followed by a grieving period. The grieving process may involve feelings like anger, resentment, sadness, and depression, followed ultimately by a sense of acceptance. What could some strategies for coping be?

## 10. SOME STRATEGIES FOR COPING

If you're facing a loss of hearing, strategies for coping with hearing loss and depression in older adults is needed. It doesn't have to define you or prevent you from living a full and happy life. Here below are some advice that can help you become empowered and proactive about your personal limitations.

i) **Visit a healthcare professional.** Hearing loss can be effectively treated and managed in ways that were not possible even a few years ago. Many people have trouble admitting they need help. But early action is important, since hearing loss left untreated can worsen.

ii) **Start with your primary care provider.** If they can't diagnose your condition, you may be referred to another professional (e.g., an audiologist, otolaryngologist, or occupational therapist) who can evaluate your situation and help you explore all your options. Depending on the type of hearing loss you have, treatment options may include one or more of the following:

- Surgery
- Hearing aids
- Auditory training
- Assistive listening devices
- Medication

Feeling nervous about seeing a doctor for your hearing loss? Ask someone you trust to accompany you to your visit. If it's your spouse or family member who is hard of hearing, assist them in scheduling an appointment and offer to go with them.

Regaining the ability to hear clearly can counter the anguish of hearing problems and restore your quality of life. A 2020 study published by *The Journal of the American Medical Association* found that the use of hearing aids reduced the risk of psychological distress resulting from hearing loss.

iii) **Seek mental health counselling.** In addition to therapeutic interventions, consider seeing a therapist who has experience working with adults who have lost their hearing. They can assist you in navigating the grieving process and develop healthy coping skills and strategies. They can even help you find meaning in your loss, so that you can continue to find joy in your life.

iv) **Surround yourself with knowledge and support.** If you or a loved one is dealing with hearing issues, you are not alone. There are many organizations that are dedicated to advancing hearing loss education and awareness. *The Hearing Loss Association of*

*America*, for example, provides information and resources on hearing loss prevention, causes, and treatments. Their website also connects you to online communities and in-person support groups in your area, where you can exchange experiences with others facing the same challenges as you.

Hearing loss and other *aging-related changes* can bring on a range of difficult emotions. If you or someone you know is experiencing depression and/or suicidal thoughts, help is available. Learn more at *SuicidePreventionLifeline.org.* And as an update to older adults and caregivers supporting a loved one, when the regulations are finalized, as early as 2022, hearing aids can be sold directly to consumers in stores or online without a medical exam or a fitting by an audiologist. Why the SA Sosity for Mental Health and Deafness?

## 11. WHY THE SASMHD?

The aim of the SASMHD is as follows, namely, to promote the mental health and wellbeing of Deaf and Deaf Blind persons and their families.

### VISION

The vision of SASMHD is the mental health and wellbeing of Deaf and DeafBlind persons and their families.

### MISSION

The mission of SASMHD is to; advocate and promote equal, accessible and appropriate mental health services at primary, secondary, and tertiary levels for Deaf persons and their families based on sound research and good practice.

11.1 The SASMHD provides a network and a database for mental health professionals and workers who render services to Deaf- and DeafBlind persons and their families who experience mental health challenges. This national and international network offers the opportunity to exchange and broaden knowledge and expertise beneficial for both service providers and users (Deaf- and DeafBlind persons and their families) of services.

11.2 The SASMHD promotes positive health and wellbeing for Deaf persons and their families through Deaf friendly and DeafBlind accessible information and support to mental health service providers.

11.3 The SASMHD advocates Sign Language proficiency amongst mental health professionals and Deaf children, Deaf parents of hearing children, Deaf children with hearing parents, hearing children with Deaf parents, Deaf professionals in mental health, teachers of Deaf learners, mental health and wellbeing forum, medication concerns.

11.4 The SASMHD supports the training of Deaf and DeafBlind persons in mental health professions.

11.5. The SASMHD organise and coordinate special interest groups or forums e.g. hearing parents of Deaf children, Deaf parents of hearing children, Deaf children with hearing parents, hearing children with Deaf parents, Deaf professionals in mental health, teachers of Deaf learners, mental health and wellbeing forum, medication concerns.

11.6. The SASMHD identify areas for research and liaise with research and training centres.

11.7. The SASMHD strife to build a diverse and committed membership basis. What about communication technology?

## 12. COMMUNICATION TECHNOLOGY

In recent years, Deaf people have benefited in the UK from advances in information technology. The wider availability of email, chat rooms and web sites have helped Deaf people to remain in touch with each other and the wider population. Minicoms and textphones are now routinely used (although less so than they could be in health care).

Two other developments in the UK are worthy of further consideration. Telemedicine is now commonly used to provide access to remote populations and to connect satellite services such as Minor Accident Units to better resourced centres. There could well be a role for this in allowing Deaf people and local service providers' access to specialist centres for consultation and advice.

The other, very recent, innovation is some work done by the charity SIGN. They have developed software which will interface with family doctor systems, and which will translate questions and advice into British Sign Language (BSL). Given the shortage of interpreters referred to above, this could have a significant impact on access to primary care in a much shorter time span than would training additional interpreters.

## 13. PRIMARY CARE

A common question was – "why are you focussing on Deaf people and mental health; we have problems going to the GP for any reason?" Of course, the consultation was specifically about Deaf people and mental health, and it would not have been practicable to widen the remit. However, it is impossible to disentangle the issues around access to mental health consultations from other GP visits.

Respondents recognized that it is impracticable for every general practice and the staff associated to provide a comprehensive service to Deaf people. However, there was consensus that it was reasonable to expect some minimum requirements.

It is hoped that Deaf people missing their turn or appointment because the only prompt was their name being called out are isolated examples but, more worrying, is evidence that Deaf people come away with very little understanding of the advice given.

A common frustration was a difficulty in obtaining interpreters and a reported reluctance from some services to fund them when available. A contrast was made with the facilities made available to other minority language users and it was hard to for Deaf people to see this as other than discrimination. The use of family members as informal interpreters was widely resented by those who responded to the consultation.

There are resources available to primary care and much that can be done for little cost. Locally, expertise can be found in social service and education departments of local authorities. There is also an information pack for general practice produced jointly by the Doctor Patient Partnership and the Royal National Institute for the Deaf8.

Reference should also be made to *Guidance on Developing local communication Support Services and Strategies*, which contains a detailed account of the policy and legislative framework, an analysis of existing provision and recommendations for commissioners.

Another main theme to emerge was that of the desirability of “one-stop-shops” or *Healthy Living Centres* which would serve a wide geography and provide a wide range of services, including general health services and health promotion. Other suggested functions include:

- access to social care, education and benefits advice,
- co-ordination points for interpreters,
- a base for advocacy,
- a source of Deaf awareness training,
- resources for parents
- classes and
- videoconferencing.

## 14. SECONDARY AND TERTIARY CARE

Secondary and care to support Deaf persons in the community as well as those being treated in local hearing-impaired inpatient units, is needed. Evaluation of this project is encouraging, and it is a good example of standard practice being sensitively adapted for use with a population with special access needs.

## 15. FORENSIC SERVICES

Deaf persons with mental health challenges appear to come to the attention of criminal justice agencies at a greater rate than would be expected. They are overrepresented in secure

mental health settings and are thought to be overrepresented in the prison (correctional service) population.

However, no figures are kept by the courts or prisons which would allow greater certainty about this. Clinicians in the specialist services all report seeing a high proportion of people who have had contact with police and the courts. Given this, it seems inevitably that some Deaf people with mental health problems will require care in some degree of security. It has been a source of concern for some time that Deaf people are:

- Held in a higher degree of security than necessary. Rampton hospital has provided a service for a small number for some time, and it is important that those who are suitable can move on to a medium secure, signing, environment.
- Contained in prisons because of a lack of a suitable health facility.
- Refused admission to specialist services because of the risk they pose.

## 16. COMMISSIONING OF SPECIALIST SERVICES

Mental Health and Deafness is defined as a specialist service in the national definition set and, therefore, one that should be commissioned through consortia arrangements representing an appropriate population size. In some parts of the country, such consortia are well established while in others they have been slower to develop.

It is important that each part of the country has a plan for meeting the mental health needs of its' Deaf population and appropriate commissioning arrangements in place.

## 17. PRISONERS AND THE CRIMINAL JUSTICE SYSTEM

The plight of Deaf prisoners was highlighted by some respondents. They argued that special provision should be made for their needs and their inability to access rehabilitation programmes means that they can, in effect, serve longer sentences than hearing prisoners. They can also miss out on basic amenities like hot water if this is announced only verbally.

There are estimated to be around 100 Deaf prisoners at any one time but there is no systematic recording of this by the Prison Service (Correctional service). It is not known how many have a mental health problem. They are dispersed throughout the prison system and that makes it more difficult, in the context of the many other pressures on the system, to make any special provision.

There are also issues at other stages in the Criminal Justice System, through arrest to trial and conviction about ensuring the individual understands the procedures and their rights.

## 18. OLDER PEOPLE

Deaf people, like everyone else, may need residential care when they get older and become frail. Most now go into residential or nursing care where their needs are not distinguished from those with acquired hearing loss. Understandably, staff do not differentiate between Deaf elders and those whose deafness has come later in life, even though they will have very different communication needs.

There are 24 nursing home places nationally for Deaf people and it is likely that this represents significant under-provision.

## 19. CARERS

We heard from several carers of Deaf people with mental health problems who raised several issues. One was about the amount of support they themselves needed and received. Some of this support was available from local networks around Deaf Clubs and voluntary organisations.

However, it needs to be remembered that such carers do have a right to have their needs assessed and that there may well be a role for the new *Carer Support Workers* in these circumstances. Developing services for carers and families of people with mental illness sets out the way in which mental health services should recognise and support carers and engage them positively in treatment.

Another issue was an uncertainty about where to turn in times of crisis and this is exacerbated by the reality that many Deaf people are likely to receive mental health care further away from their homes than hearing people. To some extent, this is an inevitable consequence of services being specialised and there is always trade-off between access and expertise.

This does place a burden on carers in terms of travel. The establishment of a network of specialist may assist in alleviating this problem by allowing fewer and briefer admissions to distant specialist providers.

## 20. ETHNIC MINORITIES

There can be issues for Deaf people within ethnic minority populations. These relate to cultural sensitivities and to multilingualism within families that can make it more difficult for an individual to function within an effective communicating environment. This is a significantly under-researched area and would helpfully feature in an over- arching needs assessment of the Deaf and Deafblind populations.

In addition, it is well documented that people from ethnic minorities in general have significant difficulty in accessing and feeling appropriately supported by mental health services *(Delivering Race Equality: A Framework for Action)*12.

## 21. EDUCATION AND EMPLOYMENT

Many Deaf children, particularly those educated in a predominantly oral tradition who do not achieve sufficient benefit through hearing aids or cochlear implantation, do not emerge from schooling with the skills needed to compete in the job market. Similarly, their route into further education will be effectively blocked.

When this is combined with the need for additional help with communication, which is patchily available, access to education and employment is severely hampered.

The need for child-centred early education has been touched on above. Similarly, there needs to be greater emphasis on communication support in primary, secondary and further education and employment, geared to the needs of the individual, if we are to avoid the level of social exclusion which has such a negative impact on the mental health of Deaf people.

## 22. WORKFORCE ISSUES

Within mental health services, it is striking how few staff are working with Deaf people and how vulnerable services are to departures. This applies to all the main professions in mental health. There are very few professionals with signing skills sufficient to equip them to carry out their work in BSL and there are retention issues for this group.

It is also striking how few Deaf people are employed in these services and this presumably relates to the access to education and employment issues mentioned above. This is an important issue, not simply because of the increased opportunity for Deaf people but because of the need for positive role models for Deaf people in general, who too often assume that a Deaf professional is, in fact, a hearing person.

Another issue raised was the amount of “out of role” activity. Social Workers and Community Psychiatric Nurses both reported accompanying clients to general practice consultations and acting as interpreters. This is wasteful of scarce resources although understandable in the circumstances and no criticism is intended of the dedicated staff involved.

Several respondents pointed to the additional training required to achieve an appropriate fluency in sign language and suggested that financial incentives would encourage recruitment and retention.

There are encouraging signs as well. A course in Psychiatric Nursing at Salford University for Deaf students seems well established and there are plans to develop similar courses elsewhere.

## 23. INTERPRETERS

Many respondents raised the issue of interpreters. There are only 168 Members of the Register of Sign Language Interpreters in the UK. Whilst there are others with skills, this is the basis on which people are engaged to work in criminal courts and this should provide a benchmark for health care. The practice of using family members, often children, as informal interpreters seems both widespread and unjustifiable in health care and particularly so in mental health.

Interpreters fund their own training and the vast majority work on a freelance basis and/or through an agency. There are a few accredited higher education courses (Bristol, Wolverhampton and Central Lancashire Universities are prominent) in Deaf studies but not all include the skills necessary to work as an interpreter.

The shortage of interpreters is a serious barrier to access to all levels of health care (and other services) for Deaf people and respondents to the consultation repeatedly stressed that this needed to be overcome before matters would improve. However, this is a complex issue and certainly not under the control of the NHS. There is the additional issue of a lack of specialist training for those interpreters who wished to work with mental health clients.

## 24. RECOMMENDATION

24.1 Consideration needs to be given to the best mechanisms for increasing the pool of skilled interpreters. This may also need to encompass the employment status of such individuals. This will need to involve several agencies.

24.2 The feasibility of developing specialist training should be explored by the specialist providers.

24.3 Attention should be given to means of increasing the number of Deaf people employed in mental health services at all levels. *Support, Time and Recovery Workers* (DH, 2003) may provide a model of how this could be done relatively quickly.

24.4 In any needs assessment, attention needs to be paid to the implications of cultural and ethnic diversity

24.5 In considering how to meet their aspirations for race equality, NHS bodies need to be aware of groups with access needs. That a pilot should be established between one of the specialist providers and a suitable remote site to explore whether further developments of this kind can be justified.

24.6 That the SASL translation software developed by SIGN is made available to primary and secondary care services as speedily as possible.

24.7 That Primary Care and Hospital Trusts to include Deaf awareness training in their training and development curricula for all front-line staff. Local voluntary groups and local authority social services departments are likely to be able to provide the appropriate expertise.

24.8 That Local Chapter Teams development focus teams to make arrangements to access the data held by Local Authorities on Deafblind people as a starting point in considering how they might meet the needs of this group.

24.9 That the specialist services consider how they wish to manage referrals of Deafblind individuals in future and what additional expertise or specialisation is required.

24.10 That consideration be given to conducting a needs assessment of Deafblind people alongside any undertaken for Deaf people.

24.11 Every primary care facility should have a minicom and a service agreement with a translation service that includes BSL.

24.12 Consideration should be given to the potential role of Gateway Workers in guiding Deaf people with a mental health problem to the service most likely to be of assistance at that time.

24.13 That a proposal for a Healthy Living Centre pilot be developed in one or two areas initially.

24.14 Primary Care Trusts should consider whether there is a practice within their boundaries who could develop a special interest in the needs of Deaf people.

24.15 That specialists are recruited to those parts of the country with the greatest need for an enhanced service.

24.16 That consideration is given to replicating the Deaf Enhanced Support Team model.

24.17 Every primary care facility should have a minicom and a service agreement with a translation service that includes SASL.

24.18 Consideration should be given to the potential role of Gateway Workers in guiding Deaf people with a mental health problem to the service most likely to be of assistance at that time. That a proposal for a Healthy Living Centre pilot be developed in one or two areas initially.

24.19 Primary Care Trusts should consider whether there is a practice within their boundaries who could develop a special interest in the needs of Deaf people.

24.20 That specialists are recruited to those parts of the country with the greatest need for an enhanced service.

24.21 That consideration is given to replicating the Deaf Enhanced Support Team model.

24.22 That the pattern of referrals, lengths of stay and eventual disposal of service users at Mayflower Hospital are carefully monitored with a view to establishing whether there is a firm case for a further unit.

24.23 Mental Health Trusts involved in Prison Inreach should seek to identify Deaf prisoners with mental health problems and seek specialist advice on their management. Alternatively, if it were possible at some stage for the Prison

24.24 Service to designate one prison as having a distinct role in managing Deaf prisoners, specialist inreach could be considered.

24.25 That local *Needs Assessments* take account of the number of Deaf elders who may require residential care.24.26 Those responsible for planning carer support should be aware of the need to consider those carers who may have needs.

24.27 Staff working in mental health settings should be encouraged to learn BSL and those in specialist services to acquire a fluency that would allow them to carry out their professional functions.

**CONCLUSION**

The recommendations in this guidance are wide-ranging and cross a few organisational boundaries. We would, however, be failing to effectively tackle the issue of Mental Health and Deafness were we to shirk that complexity.

This is also a long-term issue. There are few areas in which very rapid progress can be made and considerable co-ordination will be required if progress is to be made consistently for the whole population.

There is considerable commitment among the main stakeholders for progress to be made in an area that is widely held to have been neglected for some time.

This commitment needs to be built upon and the skills and expertise that were evident in the rich response to the consultation harnessed to make a real difference to the mental health of our Deaf population. Thank you very much for your attention and the interpreters.

**REFERENCE**

André Janse van Rensburg, Inge Petersen, Edwin Wouters, Michelle Engelbrecht, Gladys Kigozi, Pieter Fourie, Dingie van Rensburg, Piet Bracke, State and non-state mental health service collaboration in a South African district: a mixed methods study, Health Policy and

Planning, Volume 33, Issue 4, May 2018, Pages 516–527, https://doi.org/10.1093/heapol/czy017.

JH Oberholzer

18 October 2024

Facilitator: Thank you very much, Dr. Oberholzer, for your presentation. I'm sure we saw and we heard what you said, the impact, the mental health impact that deafness and deafblindness have on individuals, and the impact that it has in various ways. It's important for all of us to be aware of that, and to take note of that.

The impact is also not only on the individual, but on the family of the individuals who are deaf and blind because they live with their families, but often times their families don't understand what the challenges are and what they are dealing with. Example. let's say a deaf individual goes to a psychologist or to a professional for mental health services. But then, also. this individual's spouse goes with them. They don't understand what is involved in the process, so the family needs to be included in the consultation with the professional service provider so that they understand what is involved in the process, and that they can understand what will be expected of them as a family member to support the individual. It's not just about the individual, but about their whole environment. It must include the family and this is the view that we have, you know. Obviously, I'm talking from the perspective of a mother, the view that we have, you know. But you know whether it's a deaf or deafblind individual. We need to include the immediate family. So, thank you very much for your presentation.

So now we will have a break.  In the meantime, you can prepare your questions for all the presentations. When we come back, we will discuss those questions in a group setting for those who want to pass your questions along. Then we can have a wonderful proactive discussion when we return.

We going to gather all the presentations from all the presenters and make sure that we share that with everyone. We will compile that. So thank you very much. Let's have a break until 1230.

LUNCH BREAK

## 9. OPEN DISCUSSION

Facilitator: Everyone had some tea and had some lunch. Thank you to everyone who's joined us again. So, Tim Stones, are you back on the platform?

There’s a question for you.

9.1. I am taking Epitec and Dopaquel to treat my condition. I also wear a cochlear implant in my left ear and a very powerful hearing aid in my right ear. But we know that the devices don't give full access to sound and the hearing world. I need to focus and concentrate, which is tiring, and that is in itself for any person with a hearing loss a challenge. When added to the effects of the condition I have as well as the medicine to treat that, I find myself in a constant state of mental exhaustion. That's my main complaint with it.

Question on dental and oral health: doesn't the medicine affect your dental health? Tim: No, it hasn't affected my oral or dental health.

9.2. Convo

Jan: Question: Convo users in SA? How many users we have in South Africa of Convo users? Nobody from Convo is present. We will find out and add the answer to this document. Contact Yunini Gouden, Customer Specialist – Convo South Africa: Follow link

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840e515c62fd&psq=convo+south+africa+yuvini+gounder&u=a1aHR0cHM6Ly96YS5saW5rZWRpbi5jb2

0vaW4veXV2aW5pZ291bmRlbg&ntb=1

9.3. Susanna explains: Someone mentioned that perhaps we need to have a kind of memo with information about convo. You know, convo does not specialise in mental health issues, and if I am a social worker, I am concerned about confidentiality. So perhaps we need to discuss that with them, and we need to have a memorandum of understanding with convo about confidentiality so that the interpreters who work for convo must know the importance of confidentiality when it comes to mental health settings. You know, when an interpreter is used in a setting that discusses mental health issues. Trust is very important, and trust can be broken if confidentiality is not maintained. And then, like I said previously, we need to include the whole family. not just the deaf person or the not just the deaf person or the deafblind person. You cannot provide therapy for them in isolation. It cannot work like that, you know. The members of the family need to also understand what to do. You know, I mean, Tim's mother was amazing for him because she fought for him because sometimes you need someone to fight for you when you are incapacitated, and you cannot do it for yourself And these are things that we need to make sure of. And Dominee Smit. I'm hoping you are taking

notes, because these are my points. I don't know if there are other hands in the room. Anybody else would like to say something.

9.4. Sign Language courses: Question: Where can I learn South African Sign Language to communicate with our service users? SASMHD will make it one of its resolutions to investigate ways and means to make Sign Language training accessible and affordable and publish a list of Sign Language training services. The most affordable will be to do it is probably online. DeafSA have data on available on accredited Sign Language training. Contact DeafSA (Deaf Federation of South Africa). Also contact Dirkie Ebersohn (Deaf Professional) at NID:


9.5. Attie: Training of Deaf and DeafBlind persons in mental health professions: Attie raises the importance of the training of Deaf and Deafblind professionals as well as auxiliary mental health carers and assistants in the mental health field. If you can have centres with mental health services such staff in employment they will help to make mental health service environments more accessible for DDB- patients bridging communication barriers in the treatment environment with positive spinoffs for all staff and patients. That can be done with the support of universities and other registered training facilities. Such trained DDB staff will be a big asset in hospitals, clinics, service offices and mobile clinics in remote areas. A Deaf co-counsellor can help to bridge communication barriers and understanding of Deaf culture.

Wilma: Communication facilitators: Wilma refers to Wilma: Communication facilitators: Wilma refers to Jan's presentation. Add communication facilitators for Deaf and DeafBlind people to the list – not the same as interpreters.

9.5.1. Prof Funeka responds: Training of Deaf persons in the mental health field: She echoes the need for culturally Deaf and DeafBlind professionals in different spheres, and especially in the mental health care. We have previously raised this as an issue, and our exploration, for instance, at our university level we were having a short discussion just now. Seated within our meeting today, we have drawn in individuals who are in our transformation structures within the university and the discussion currently taken place is at systems like faculty or health sciences and other faculties, where are the culturally deaf people or any other person who may have difficulty accessing things the way that education systems are designed at our universities now? One of our duties that we are

walking away with today is where are the Deaf students and what are the barriers, to accessing certain priority training programs? The quality of Deaf education in our country becomes a barrier at times. I hear the big call for deaf, deafblind individuals and individuals who become deaf later in life – these are the areas we zoom into. Things seem to move slowly like at a time was the recognition, accepting and including SASL as the 12th official language in SA. And when are we going to begin? And so yes, looks like we're going around in circles. But I think it's the point Tim and I have made. you know in this space, where things appear to be working slowly. We need to have individuals in rooms where these discussions are being had. That's not enough. We need to make it an imperative.

You inspire all of us, and how, for instance, the South African sign language debacle was wrong but through insistence, we watched, we advocated. Sometimes it looked like it was not going to happen. But look at us now and I mean some of us started talking about 12 languages in the classroom and people would look up. So, today you raise interest already to really make us aware of the richness all around us. And instead of the binary fusions we have been, you know, trapped in. Yes, so it's a lot of work but it's work that is doable.

I look forward to the results of the deliberations that will come out now in terms of what we do next. From our side, we are carving and will communicate through our secretariat in terms of how as a department and then as a system. I was heartened today by all the presenters. And I like to thank everyone. We definitely will be making contact to learn from live examples. I mean, Susanna, yeah, I think this is my last. I bow down to anyone who's in med's group.

Today you have inspired us, and especially the presenters. I wish for people to get into the academic space, like yourselves. So please all presenters, please carry on!

9.5.2. Dr Wilma: Thank you so much, Professor. Thank you. The question we need to keep in mind is when we are stuck, or when all our people are not listening. So, it's time for people to listen to what deaf persons who went through the mental health system when they are now adults, they can talk for themselves with a sign language interpreter to share their experiences, and then also for people to listen to what they shared, what their experiences are.

9.5.3. Susanna: Dominee Attie mentioned exactly that. And we need to add that so for example in universities, we need to make sure that deaf professionals can be trained and then also, what we've learned is that deaf mentors can be added to this profession. and that the name High Hopes is one of those that teach that kind of mentorship

programs that are available here in South Africa. That is a deaf mentorship program that assists families and involves families getting into the stuff. People need to send in their applications and CVs. Get the experience from a deaf mentorship program and apply for the mentorship programs available in South Africa at the University of the Witwatersrand - get to understand Deaf Culture.


Let me share some of my notes: I feel it's of crucial importance that when a deaf person goes through Covid and post-Covid, for example in America a deaf friend at the university who had frustrations because the interpreters did not want to go to the hospital and to be in person. They prefer to be online. How much did COVID-19 impact deaf people here in South Africa, deaf and deafblind persons, and the mask that prevented us from lip reading mental health professionals. In South Africa we use South African Sign Language, we have everything. We have interpreters, but in the medical professions, if there is no understanding of Deaf Culture, then it is not worth having South African Sign Language training. They are so involved in the hearing world culture that they don't understand what we are experiencing every day, they need to have a thorough understanding of Deaf Culture[9]. This leads to labelling e.g. Some deaf people prefer to talk *(sometimes using the Sign Language structure*). Some deaf people prefer to use South African Sign Language. Some deaf people can brilliantly read lips. Not everyone can do that. Some deaf people try to share notes, but some deaf people do not like to share notes. There's a difference in sharing notes, and sometimes I write in the South African signing structure of the sentence. But then deaf people, hearing people think that they are not educated because of the way how they write. Hearing people need to understand that kind of behaviour. Sometimes people think you are angry. It's maybe just being passionate. I've been misunderstood so many times. I'm not angry. There's a difference. People think that I'm emotional, but I'm

9 Attie's note: Quoting Prof Johannes Fellinger, the child of a culturally Deaf father (Austria): Deaf persons experience at least 30% more frustration stress than hearing people

passionate that can also be a label that could be on deaf people. So medical professionals also need to understand that.

9.6. Website (Susanna): And one person talk about the website, especially for government website, where they can get South African signing classes. Where deaf people can contact information on mental health services for deaf people in SASL. I think a website is very important, and if the government can really update their website. So it's also including South African sign language and social media, we use that fully because our young people are using that fully because our young people are there on social media. So we also need to use that for our benefit as well.

The website can become a HUB (see Murdock's presentation)

Folio: We also need to look at Folio, because the funding is depleted, or they still need funds. So I know that folio is not in all the provinces, that only here in the Western Cape. so we don't have that kind of facilhave that kind of facility in other provinces where folio can be duplicated in other provinces, and so that they can be the role model in understanding how to use interpreters in a medical setting. *(Professional Translation & Language Services Company | Folio Online*

9.8. Free interpreting services: Susanna: So many times, I thought, government institutions must provide interpreting services for free. But our medical aids? - I haven't looked at the laws that govern medical aid, but does medical aid provide? They provide hearing facilities, but they do not cover South African signage. Interpreter costs. Why are they not covering that? Maybe we need to lobby the Medical Aid Council to make provision? They do pay for hearing aids through Medical aids? But why not paying for interpreters? Why can't they pay for that through the medical aid? Maybe we need to consider that. Dr Wilma: Yes, Susanna. I wish to add to what you are saying. About the medical aid situation. I completely agree with you. I fully support your statement, they should be paying for sign language, and interpreting services. And I'm just wondering when I go to the USA. I always ask who pays for the interpreting services, and then they say health insurance. So, their system is different. So, they say the health insurance covers sign language interpreting services. I think contact should be made with someone there to find out how they did it so that we can implement it in South Africa, it is a great idea. I think that is a good suggestion. Thank you for that.

9.9. Inclusive. Inclusivity is the word. You know, many potential avenues can impact the lives of deaf people, and we need to be inclusive. Everybody can be inclusive in education, etc. You know, anybody can become disabled through an accident. Rehabilitation is then provided. But why is rehab not given to deaf people, you know, if

you find a deaf, blind individual, why are we not being inclusive in services that we are rendering? We need to provide training to all professionals, to psychiatrists, psychologists, all medical professionals, mental health professionals. We should not be selective. We must be inclusive in everything that we do. Yeah, I think I have covered it all. “Inclusive” services can be very selective in who they serve.

9.10. Facilitator: Ds Jan, Yes, you ask your questions

9.10.1. Trauma: So the 1st question, that I need to raise is I'm busy for the last 10 months in a program that helps people **with peer group trauma handling and that I would very much like deaf people to have that as a program. My first question is with confidentiality.** So I'm very supportive of the notion that deaf people know their own context, their own life the best. So this program also underlines the fact that when I, for instance, have a trauma and another person is a good listener, I can tell my story within a confidential space. as we already explained, a safe space. But now the challenge that I have is, for example, I share my traumatic experience with another deaf person that is very good in sign language and deaf culture and deaf community and would understand me perfectly. But how am I sure that this person won't share my story, or what happened to me in the whole community? Is there any solution to that, please? That's my 1st question. Should I continue with my second? Thank you very much. I've experienced some deaf people.

9.10.2. Alcoholism. So **my second question is regarding alcoholism.** People who have challenges with alcoholism. So I take them to a place where they deal with the mental issues regarding drugs and dealing with addiction. So it is all in your brain as I as I know, there's a part in your brain that deals with addiction. So alcoholism is one of addictions that one might have. So if there's no label you, you don't get labeled as a alcoholic. Some people are have a eating disorder, etcetera. So it's a mental health issue. So then this place Rehab Center tells me that they do have individual therapy, but they mainly make use of group sessions. And then this deaf person is the only deaf in that group. How can one deal with that question of group or peer, Maybe the South African Society for Mental Health and Deafness make a difference in people who have addiction problems or challenges and also have some trauma because I really think that deaf people are traumatised just from the age of 3, when they when they are left at school.

Tim: Thank you. So my thoughts on the issue with alcoholism and deaf people. Is to start off with that. The way that. And I know this from family members who've attended. I've experienced it myself with family members through the process of alcoholism. The

whole way that it's approached is in a group therapy session. It's very, little individual counselling. It is all about the peer support and yeah, well, I think that's it. And now, we're thinking, how do you make an individual deaf person feel comfortable in this space? Follow the processes. You're able to open up and also be assisted appropriately and fully to my thinking, there are 2 problems here. The one is with the digital support. So okay, we could do the counseling via online cell phones, mobile technology that's far from ideal. How? How does that really help a person with such a problem, such a challenge as alcoholism, that person is likely to be sitting on her or his own somewhere or at home. Not being able to draw on the energy and see the interactions and feel and draw on the emotional energy and feel the emotional support that's coming from others who are also on a journey with alcohol addiction that would just in my view. my perspective is that would just exacerbate the person's feelings of isolation loneliness and despair. So I don't think a digital approach would work. Then I don't like the approach of a casually deaf person. being in isolation with just hearing people following a hearing culture approach to therapy, a hearing culture a hearing culture approach to counselling. hearing, culture, language, hearing, culture, and expressions that are not appropriate for a culturally deaf person. They need to be amongst their own community. like-minded people who share their experiences, not just with the alcohol or the addiction issues, but with the challenges of deafness going forward. I would love us then to look at one of our resolutions to be, how, then, do we make type services for these people. more accessible as a community in and of itself, not in conjunction with hearing people who are going through alcoholism, but just focus only on deaf people. Wouldn't it be wonderful if at some point we could identify a building? A room even where just deaf people go to and have a qualified professional who is experienced with deaf culture and alcoholism support so that they can just be focused on as a unique special community that for me, is what SASMHD should rather focus our energy on, instead of focusing energy on, how do we make an individual or 2 deaf people fit in better in the hearing approach**.** Thank you.

Facilitator: Thank you so much, Tim. Thank you. And I absolutely agree with you. You know I always, look at providing services but I do agree that it would be best for a whole group of deaf people to get together. However, you know. I mean, I know that zoom is not the best but you know the future is already here, and Zoom is the future, and I think perhaps we need to look at using that. I know it's not the best, and I know getting together in a physical space together with like-minded people, is the best.

9.10.3. There was one lady. If I can just give you an example. I don't want to waste your time. But there was a lady who had Alzheimer's, and she was in Rusoord here in Bellville.

And every day she stood at her window, and she walked out into the garden. And she was crying, Mama! Mama, come, help me come! Come. So she was traumatised the day that her mother or her parents left her at the school. So now she's aged, and she's got Alzheimer's, but she can still remember that trauma. So maybe if we can deal with that trauma situation before they get some elderly person, or there are many traumas that deaf people sometimes exclusive from hearing people's experiences. So then they could be relieved. But I struggle with this people, telling other people what my traumas are, and the confidentiality with this, and then also the group therapy. Thank you.

9.10.4. Facilitator: Wonderful. Thank you. As the facilitator. I'm asking for your permission that I provide a response if that's permitted. Thank you. In terms of trauma Dominee Oberholzer trauma and confidentiality. You know, personally, I am a trainer of deaf social auxiliary workers because I am the only deaf social worker in South Africa who can use South African sign language. You know there are others who are hard of hearing and don't use South African sign language. My biggest emphasis in my training is confidentiality, and I think when we provide training to mental health facilitators who teach deaf people, you must emphasise the issue of confidentiality, and the second matter is boundaries. It was in the deaf community. Of course, it's a small community, and you know they must learn to keep things confidential, and if they cannot keep it confidential, they have to share it with a supervisor only because the supervisor is responsible for all social auxiliary workers, and when they are still in training you know, of course, you have to. Always, when you are in training to work with mental health cases, you will have a supervisor, and there is a huge need for confidentiality, and that must be emphasised with deaf persons who are studying that. And your second thing about the trauma and this elderly person I mean, unfortunately, who now have Alzheimer's. But that trauma reoccurs. I'm sorry I don't have a response, for that. You know, at home, perhaps I mean, they can have a social worker where they live. Maybe they can. I don't know if it can work, but perhaps there is a person who is trained to deal with or to sit down with this person, and to deal with that trauma.

9.10.5. Medical and Education professions must be taught: You know, in terms of the universities, we must educate them about deaf people. The higher education institutions, and those who are studying to work in medical professions must be taught and not about disabled persons specifically, but about deaf people, specifically, because at the age of 3, if you are taken to a school, and you know you are left there by your parents. You know what it's important for someone at the school to explain to

this 3 year old that mommy and dad are going to leave you here because of the volley[10], so the parents should be able to sign, and in that case they can explain. But especially, you know, people who have deaf children. They have no idea they just leave their children there. But today let us learn from the traumas of those who experience those traumas 20, 30, 40 years ago. So let us work with our children who are there now, you know, I mean we must explain to those children that there is no other school. and that you are left here because there's no school in your home area, and that's why you got to be in a hostel, etc. etc. So provide an explanation. I mean, you can deal with that. But Alzheimer's to deal with the trauma of someone that's old now, and had experienced a trauma in the past. Whoa! I don't know**.**

9.10.6. Group work: Susanna: I wish to add for you know, in in America we have deaf counsellors where we can work in groups, we can do group counselling. So one person will, for example, specialise in narcissism. And and there's a group that specialises with deaf people who have narcissistic behavior. Then another group with another specific disorder. You know, we can also, you know, have it on Zoom. However, someone has to pay for the zoom connection, and I think it's a hundred $30 to join that specific group. And I think, you know, when we look at discussing matters with medical aids, then perhaps this is something that the medical aid can cover in South Africa. If we have a group of deaf counselors, Susanna**:** I know that there is a person by the name of Anel her last name or a surname is Koekemoer. And now Koekemoer has studied, and you know she has studied counselling, and I so hope that she will join us and start. you know, perhaps just an informal group form a group with all counsellors**.** Social workers can be a part of that group, too, and I think that'll be amazing to establish a group like that so that we can get services going**.**

Wilma. Yeah. But I think it would really depend on who would manage the group. And I think, in terms of Jan's question about the trauma or the addiction counselling is maybe a social worker who work full time with deaf people can accompany that deaf person that suffers from addiction to attend the group session just to provide access for the deaf person. But I mean, I know that some deaf people don't want that either. There are various ways in which one can make these group sessions accessible. It's like Susanna said. Have this on Zoom. However. I'm think in a WhatsApp group you can have up to 45 people in that group. However, it's gonna cost money. If people can come to the DeafSA offices where there is Wi-fi available, then they can sit down in a private

[10] Volley: A lot of unexplainable or unclear things or questions or overburdening circumstances

room. Perhaps that's the way in which one can include a deaf person in those addiction group sessions.

9.11. The need for training: Prof. Funeka: So from our academic settings, we know now the need for training. Actually, we've known it all along, the training of individuals and professionals who are sensitised. Now, Secretariat, if I can ask that we take the use of technology as a point of focus going forward in line with the presentation of Susanna today, bringing all the rich elements of this conference together. We need to create a point on the digitisation of mental health care services going forward with our various partners that have been mentioned now already. With the funded care system and private medical aids, we are moving forward, and there's a promise to move to the national health insurance. So, I think, you know, in the public sector, these conversations need to take place as well. We've already said in our spheres that these conversations need to take place as well. We've already said in our spheres, we are not able to move and to generalise services without government. So I think when you create the focus on digitisation of mental health care services, bring in critical partners, but the government is at the core of it. We may even find that our bargaining will open up spaces so that we don't struggle from a place of poverty but from a place of opportunity. I think I think I'll leave it there.

Facilitator: Oh, thank you so much. Prof. Funeka. Appreciate that

Facilitator: Jan, over to you

9.12. Narcissistic Sorry, thank you, ma'am Facilitator. Thank you for the time. It's just a small issue. I know it's a small, but for me, it's a huge issue. It's like a new trend that people label other people by saying that they are narcissistic. So, in the past one would say, Okay, that deaf person is a very difficult person, and then we label that person as being difficult. But it seems to me in recent times that people will label other people as being narcissistic. and that seems to me a little bit on the mental health side of making a diagnosis/degrading a person as a human being by other people that firstly, they've heard this trend word like narcissistic, they know also the sign for it, and then they blame other people for that. Maybe it's a small issue. Maybe it isn't difficult, but we just need to take note of that. It bothers me that one deaf person would blame, accuse or diagnose a person like “you, are narcissistic.” You know, and that bothers me in the mental health field that we are talking about today. I won't ask any other questions, but thank you for listening to that. Look at this.

Facilitator: No, not at all. Jan, I must say that. It's true, and you know, unfortunately, you know the trend of social media, of course, it brings about other things, too, and

people learn about narcissism or other trendy words. And we need to learn to cope with that. And we need to educate deaf people from a young age. You know, social media has its pros and cons. And I think we need to find a balance there. Facilitator: Tim, you've got your hand up.

Tim: Yes, just to add also to what you've just said, Wilma, which is exactly, broadly what I was going to say. Dominee Jan, thank you. That's a crucial reminder that everybody needs to think about the language and words we use to describe other people, and how we engage with other people. There is power in the words we use, power to build people up and break people down. And it's not just a phenomenon in the deaf community. It's everywhere.

But we, as SASMHD would have a responsibility then to address that in the deaf community and to go into the schools, we should have professionals that go into the schools and request platforms to conduct workshops and training exercises with young people in a way that they would know far better than I can describe to reach their people and equip them with the correct way and the better way in which to engage with each other socially. And that would help them when they become adults, and perhaps change the cycle of verbal abuse.

Susanna: So the impact, you know, is that often we as deaf people tend to put other deaf people down. So, I think it's important to include it in the education to make sure that from a very young age, deaf kids realise the impact that stigmatising others has. And they need to understand.

Facilitator: Yes, we need to break that cycle. We need to make sure that they understand the impact of that and then break the cycle by means of that. Just one moment, please. Tim asked to leave for 15 minutes to fetch his son from school. In the meantime, Ds At will stand in for him.

9.13. Susanna: So I've got more important points I want to touch on. We need the influence from the Deaf community and the groups and we need to set up the website we discussed earlier. I want to emphasise the following points:

- Training of facilitators *(deaf communication facilitators and deaf mentors?)*
- We need influence from the deaf community, the groups, and the website that we talked about, we need to set that up to get input from the Deaf.
- The hologram technology that I shared. The AI. We need to look at the possibilities of that.
- You know the coding for mental health. Specifically, the medical aid. They need to cover the costs of interpreters

If we can focus on these 4 points.

Facilitator: Thank you for that, Susan. Thank you very much for your contribution. Facilitator: Dominee At, over to you.

9.14. **Conclusion and What's Next**. Ds At: It is necessary for us to sum up and to give some guidelines for the way forward, because next week we must be starting to formalise resolutions and a plan of action. We had a nice and inspiring conference but now we must start something meaningful. I am asking **this conference to appoint a workgroup to draft a report of the conference, propose resolutions and an action plan for submission to the SASMHD Executive Committee, using this conference as a resource event.** A few people can sit down with the recording analyse it and make sure that we do not miss anything when drafting the report, the resolutions and the action plan, keeping in mind the conference is very much about reaching goals through collaboration. Collaboration - to make work all that we have discussed, we will need cooperation from individuals and organisations with wisdom, knowledge, capacity, passion, and investors to help us make SASMHD a financially sustainable organisation. We need collaboration to capacitate SASMHD to do what it stands for. How are we going to capacitate SASMHD with active members and persons willing to serve on the Executive Committee. We need people who are committed, passionate, persistent and driven.

9.14.1. From the start of this conference; the opening address by Mr Tim Stones , SASMHD chairperson, the welcome address by Prof Funeka HOD of UP Psychiatry, the facilitation by Dr Wilma Newhoudt- Druchen and her inputs during the conference, the presentations by Ms Susanna Krige -Henderson, Mr Philp Dobson, Dr Murdock Henderson, Rev.Dr. Jan Oberholzer and vibrant discussion during the Open discussion session we were blessed with a richness of wisdom and insights, grassroots lived experience knowledge, loads of ideas, and information on new developments and technology. So, to quote Prof Funeka: "There's a lot of work but it is doable".

9.14.2. Tim: We must get the person who's going to do the coordination or the convener. I don't know if we must perhaps, we must look at who is the youngest in the group and give it to that person.

Wilma: I think it's Susanna

Susanna: I don't have that much experience with multiple roles, but I can try to manage it. I think it might be a match between Wilma and me. I'll accept that responsibility.

At: Thank you! I will gather all the information and make a first draft and then you and Wilma can take it from there with the rest of the group to get all the plans together. I will be in the background for support. And Susanna, you are the person with the most experience of all the relevant technology. We will need your skills and knowledge. Then we will have other people in the group with capacities and competencies to support you and Wilma.

Wilma: You know I don't mind proofreading the document. You know I can assist in that manner.

At: That would be wonderful. Yes, because then we know we will have an excellent document. Thank you. You are welcome to add to it and edit it. So, you are going to be the final editor.

Wilma: I will do so. I know Bruno also has been watching some of the presentations.

At: Yeah, he's very welcome, he will make precious inputs. So, I will contact him. Just give him time to rest and get well.

9.14.3. Discussion regarding workgroup members follows. Six plus the CEO DeafSA, SASMHD Executive

Secretary, SASMHD Secretary Admin.

At: The Conference appoints the following Workgroup: SASMHD Workgroup ExcoPlus Conference Report 2024

Purpose of the workgroup:

To draft the SASMHD ExcoPlus Conference Report for submission to the Executive Committee. Members of the SASMHD ExcoPlus Work Group appointed by the conference:

Wilma Newhoudt-Druchen (Editor, Liaison with Coordinator), Susanna Krige-Henderson(Coordinator, Liaison with Editor, Graphic Design, Social Media, Website, SASL Teaser Video), Jan Oberholzer (Leader and SASMHD Office), Tim Stones (Chair SASMHD, language monitoring, and research), Philip Dobson (Vice-Chair SASMHD, DeafBlind content and networking), Fiona Singh-Beerajh (WKH Chapter input, UPWKH-MOU Compliance), Stephen James (Executive Secretary, UPWKH--MOU Compliance, Liaison with HOD Psychiatry), Anel Koekemoer (proposed by Susanna, a Student in Counselling with understanding of Deaf Culture), Bruno Druchen (DeafSA, Adviser, Advocacy), Attie Smit (Secretary admin, first draft of report).

9.14.4. Philip: I propose that

- we look at the resolutions of the Africa Workshop on Mental Health and Deafness of 2004
- Also add the 4 points that Susanna mentioned as a resolution.

9.14.5. Susanna: So, once we've established the website and we've included text information, I would suggest, that we include a very short like Teaser video on Facebook and social media to inform the deaf community about the fact that we've established this website and that this information is available, and that it is available in sign language. I can, you know, make a draft website on my side with information I feel is important, and then I will pass it on to you. At: Thank you.

At: Dr. Wilma, if there's anything that we can do to ease your task, please let me know.

9.14.6. Wilma: Yes, I think like, we discussed now for the initial 6 individuals. I think we can get going with them and see what the outcomes are, you know, from today's platform and discussion. So thank you very much for all your contributions so far, and all the feedback that you have provided.

At: So, I will hand it over to Tim for the wrapping up, and conclusion.

9.14.7. Tim: Thank you. I didn't have much to add, except I would again like to thank all of you for the time that you have set aside today. And well done also for overcoming all the logistical challenges that we had earlier. I'm so grateful that you were able to do that and able to take part in what has been a most informative, most interesting discussion. There is still, of course, much more to discuss. And I'm looking forward to working and collaborating with this team and putting in a team effort, sharing ideas. And it's so nice that it's so diverse as well. We're all coming from very different backgrounds, different depths, cultural experiences and different life experiences different experiences with mental health and deafness. And we're going to pull all of these resources and experiences together to what I'm sure we can agree will be a most interesting and helpful way forward. And Susanna. Thank you very much. I will have a chat with you after this meeting to discuss how we're going to take this forward, so I'll work closely with you. To ensure that this happens as easily and smoothly as possible. All the speakers that have been involved today. Thank you so much for your well-researched presentations. Not only good and interesting presentations, but really very well researched. It's obvious that you put a lot of time and effort into this, and it is noticed, it is recognised, and it is very deeply appreciated. It's so nice to see everyone again. It's been a very long time since we were able to connect, which is not good for our mental health. If you spend this much time apart. So it's so nice to reconnect. And and

hopefully we will do this on a more regular basis. This is a really important day in SASMHD's chapter. It's been a very long time since we had something like this and I hope that this will launch us into being able to do something similar on a more regular basis. There are so many ideas and thoughts that were shared so many challenges clearly but also what came across with we don't need to be despondent. We certainly don't need to lose hope. There's much that has happened, and much that we have to build on. So we already have a platform. We just need to carry on working together and growing as we move forward. So thank you very, very much.

And I wish you all a pleasant day further and let's keep connected.

9.14.8. At: At the end of our conference, I would like to say a few words of thanks.

- Firstly, a big and heartfelt thank you to our highly qualified and knowledgeable facilitator, Dr Wilma Newhoudt-Druchen. Thank you for your immediate positive response when I asked you to do it. You enriched us with your experience and wealth of knowledge and wisdom. It was the right decision to have you here to lead us through the process – I think it's the first of its kind in South Africa.
- Our appreciation, reverence and gratitude to Ms Susanna Krige-Henderson, Mr Philip Dobson, Dr Murdock Henderson, Dr Jan Oberholzer for your groundbreaking and impactful presentations and participation in our discussions.
- Prof Funeka Sokudela. Our high appreciation for your welcome address on behalf of the University Pretoria and as Head of the UP Department of Psychiatry. You paved the way for a high-quality awareness and guiding experience for all attendees. We have good memories of your time as chairperson and leader of SASMHD before 2018.
- The University Stellenbosch Language and Sign Language Centre provided the Zoom platform with supporting staff as well as two SASL interpreters, Mr Gert Erasmus and Ms Marsanne Neethling, with subtitles and a recording for free. Thank you made this conference accessible to all online.
- SASLINC's Ms Thelma Kotze joined the interpreter team for free. Thank you for your international and high-level professional service and support over many years.
- DeafSA made a senior staff member, Mr Francois Deysel, available for free to be part of the interpreter team. We appreciate your services as an excellent interpreter and communicator, especially during facilitation and the discussion session.
- To Mr Bruno Druchen. Bruno we have missed you here today. But we understand the situation. We thank you for your positive approach towards us and what we are trying to do. We wish you a speedy recovery. We look forward to working together on what we have started with this conference.

So thank you, everybody who was part of this conference. We appreciate you being here and hope that you find it informative and a learning and awareness-raising experience. Looking forward to seeing you again.

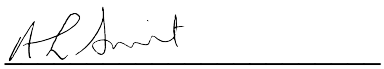
**10. ADJOURNMENT**

Attie: Chairperson, it is over to you

Tim Stones: Thank you.

The interpreters from my side also have checked this, and really we cannot do this without the interpreters. You must be exhausted at this point. Thank you so much for everything you put into your time, energy, and efforts. Your charisma. the way you do it. It is an essential service. It's deeply appreciated. None of this is possible without those few interpreters. So thank you. Thank you very, very much.

And also I echo the sentiments expressed for Wilma. Thank you very, deeply for your reflective commentaries, your thoughts, and you're giving up yourself. We appreciate that very, very much. So, we will carry on the conversation after this. But thank you very much. I think that wraps up what has been a beautiful and thought-provoking day. I adjourn the meeting.



Attie Smit
secretary@sasmhd.org
29/03/2025

**Epilogue**

Paraphrasing Prof Funeka Sokudela, HOD UP Department of Psychiatry (18 October 2024):

This conference has already raised interest on this day
It makes us aware of the richness all around us
We really now look into the questions that confront us
We need deaf and deafblind mental health professionals,
auxiliary carers, communication facilitators and mentors
We need to explore and use the advantages of new technology
We need to extend collaboration
We need smart* resolutions to guide us
There's a lot of work to be done, but it is doable.
Our imperative is: If it is to be, it is up to us

*s=specific, m=measurable, a=achievable, r=realistic, t=timely

## 11. ATTENDANCE LIST

| No | Surname | Name/initials | Title | Language | Notes |
|---|---|---|---|---|---|
| 1 | Blom | Thys | Cllr | English | Cape Winelands District Municipality. Ambassador for Persons with Disabilities |
| 2 | Kanda | Meba Alphonse | Dr | English | Clinical Manager Weskoppies Hospital |
| 3 | Gouws | Michelle | Miss | English | Student Social Worker |
| 4 | Ryk | Ursula | Miss | English | Social Worker |
| 5 | Kellerman | Suretha | Mrs | English | Auxiliary Nurse & Residential Manager |
| 6 | Gouws | Cara | Ms | English | Weskoppies Hospitaal |
| 7 | Tim | Stones | Mr | English | Chairperson, Executive Committee |
| 8 | Dobson | Philip | Mr | SASL, English | Vice-chairperson, Executive Committee |
| 9 | James | Stephen | Mr | English | Secretary, Executive Committee |
| 10 | Singh-Beerajh | Fiona | Mrs | English | Treasurer, Executive Committee |
| 11 | Smit | Attie | Rev | English, SASL | Secretary Amin, Executive Committee |
| 12 | Moeketsi | Tshepiso | Dr | English | Member Executive Committee |
| 13 | Oberholzer | Jan | Dr/Rev | English, SASL | Member Executive Committee |
| 14 | Mamafha | Thifhu | Ms | English | Member Executive Committee |
| 15 | Van Vollenhoven | Elize | Ms | English | Member Executive Committee |
| 16 | Wanza | Betty | Rev | SASL, Afrikaans | Member Western Cape Chapter |
| 17 | Kilian | Trudie | Mrs | English | Member Western Cape Chapter |
| 18 | Partington | Porchia | Ms | English | Member Western Cape Chapter |
| 19 | Sokudela | Funeka | Prof | English | HOD of UP Psychiatry, Mental Health Expert on Executive Committee |
| 20 | Newhoudt-Druchen | Wilma | Dr | SASL, English | Facilitator, Deaf Professional and Leader<br>Social Worker, Alumnus and Board Member Gallaudet University<br>Member of Parliament |
| 21 | Druchen | Bruno | Mr | SASL, English | CEO DeafSA |
| 22 | Henderson | Murdock | Dr | ASL, English | Presenter, Clinical Psychologist, Deaf USA |
| 23 | Krige-Henderson | Susanna | Ms | ASL, SASL, English | Presenter<br>Deaf Professional, MA Mathematics, Deaf Educator, Retired Lecturer Gallaudet University |
| 24 | Oberholzer | Jan | Dr | English | Presenter<br>Pastor at De la Bat Deaf Church, Belville |
| 25 | Krige | Frans | Dr | English | Medical Doctor |