New mental health services for deaf patients

A new service promises to break down some of the barriers to mental health care faced by people with hearing losses.

At Canada's first tertiary care Mental Health Services for the Deaf (MHSD) at Regional Mental Health Care (RMHC) in London, Ont., services are provided by hearing psychiatrist Dr. Elizabeth Lock and by Canada's only deaf clinical psychologst, Dr. Cathy Chovaz McKinnon, along with a part-time nurse. Services are available in American Sign Language (ASL), total communication and in spoken English and French. Presently, the service isn't offered in La Langue des Signes Québécoise (LSQ). Interpreters and intervenors are used when needed.

Lock says physicians don't receive regular training in treating deaf patients so "they are not aware of why the services are inaccessible."

Patients who are deaf, deafened, hard of hearing and deaf–blind face tremendous barriers in accessing health care in general and mental health services in particular.

Commonly, when deaf patients attempt to communicate in sign language, "they are often mistaken by medical professionals to be exhibiting 'bizarre behaviours,' 'physical agitation' or 'violent gestures.'" Because they are often misunderstood, Lock says "deaf patients are frequently misdiagnosed, not communicated with, not given informed care" and have "unnecessarily long hospital stays."

Lock says many people think deaf people "should" or "can" communicate in English or French. Yet for many reasons most individuals who have been deaf since birth do not acquire facility in English, which is also often their second language. Lock stresses lip reading is also problematic because only 25%-30% of English sounds are visible externally. This makes conversation difficult to grasp, especially if one has never heard spoken language.

Lock adds that few physicians are aware of Supreme Court ruling (*Eldridge* v. *British Columbia*, 1997) or know how to get a certified interpreter. Certified interpreters must be provided for deaf patients; thus laypersons and families should not be used.

Mark Hamon, St. Joseph's Health Care

Dr. Cathy Chovaz McKinnon (left) signing with Dr. Elizabeth Lock

Miscommunication "can result in admissions to psychiatric facilities when there is no psychiatric problem," says Lock. In "such cases, the medical problem can be missed altogether." Similarly, when deaf people write answers on paper, they may do so using ASL grammar but English words," which can produce further misunderstanding or misdiagnosis".

Common misdiagnoses are psychosis, hyperactivity, ADHD or mental deficiency

Currently, MHSD offers tertiary care for deaf, deafened, hard of hearing and deaf–blind individuals in southwestern Ontario. This area is densely populated and London is home to Robarts School for the Deaf. An estimated 7000 persons will need the services in London. MHSD provides in- and outpatient mental health assessment and treatment and will provide mental health care to individuals with a serious mental health disorder. MHSD hopes eventually be able to service other parts of Canada.

"We guide our care based on the level of need and strive to work with family doctors, specialists and community services to provide shared care type of service. Our goal is that of mental wellness and to provide ethically, linguistically and culturally appropriate quality service," Lock advises.

MHSD also offers learning and research opportunities for University of Western Ontario medical, psychology and nursing students.

Both Lock and Chovaz McKinnon worked for years to create similar programs in different areas of Canada. Dr. Sandra Fisman, chair and chief of the department of psychiatry for St. Joseph's Health Care, London Health Sciences Centre and University of Western Ontario brought both professionals to RMHC London. — Lynne Swanson, London, Ont.

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Decline in breast cancer since HRT study

Although the causal link hasn't been conclusively established, US researchers say there's been a remarkable decline in breast cancer rates since fewer women began taking hormone replacement therapy (HRT) to alleviate the symptoms of menopause.

The overall incidence of breast cancer in the US declined 7% between 2002 and 2003, while the number of women aged 50–69 diagnosed with estrogen receptor positive (ER-positive) breast can-

cer declined 12% over the same period, when millions of women stopped taking HRT after the release of a July 2002 Women's Health Initiative study indicating HRT bore more risks than benefits.

Some 14 000 fewer women were diagnosed with breast cancer in 2003 than in 2002, when an estimated 203 500 cases were diagnosed, researchers at the University of Texas MC Anderson Cancer Center told the 29th annual San Antonio Breast Cancer Symposium last month.

Senior investigator and MC Anderson Professor Dr. Donald Berry stated that the findings suggest the magnitude of the RT effect may be "much greater than originally thought." But colleague Dr. Peter Ravdin cautioned the link can only be "indirectly" inferred.

The investigators also indicated it's unclear whether the decline will continue or whether women have merely delayed diagnosis by slowing the growth of tumours that fall under mammography's radar.

In other findings presented at the symposium, Canadian researchers Dr. Margot Burnell and Dr. Mark Levine said a clinical trial of 3 commonly used chemotherapy regimes indicates CEF (a combination of cyclophosphamide, epirubicin and fluorouracil) is more effective at preventing breast cancer recurrence than the widely used AC/T (doxorubicin and cyclophosphamide followed by paclitaxel) or the more rarely used new regime EC/T (epirubicin and cylcophosphamide, followed by paclitaxel).

The trial, which tracked (for 30 months) 2104 North American women aged under 60 who had been diagnosed with lymph-node-positive or high-risk node-negative breast cancer and who'd undergone surgery, found the 3-year recurrence-free survival rate for CET was 90.1%, as compared to 89.5% for EC/T and 85% for AC/T.

The investigators stressed those variable rates must be weighed against potential side effects. AC/T users can suffer from neurological effects (commonly called "chemo brain"), and women on CEF and EC/T have a higher incidence of heart and blood problems.
— Wayne Kondro, *CMAJ*

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Wasting emergency aid in Africa

Aid organization CARE International says with 120 million Africans living "on the edge of emergency" due to hunger, donor agencies need to review their response to these emergencies, or billions of dollars of aid monies will continue being squandered.

In a report issued in October, CARE projected the world will have spent $309 billion fighting emergencies in Africa by 2020 but asserted that $247 billion, spent differently, could successfully halve hunger on the continent by 2015. CARE spokesman Amber Meikle argued in an interview with *CMAJ* that by funnelling monies into programs that help people recover from emergencies, "we could put a stop to the emergencies altogether."

The report contends that the solution lies in increased funding for, and more emphasis on, long-term development projects that help people recover from emergencies and prevent them from arising again.

Rarely is a lack of food the underlying cause of emergency, the report says. Rather, the root of the problem relates to issues such as HIV infection rates, weaknesses in the local markets, climate change, or even a simple lack of cash that makes people vulnerable to emergencies. The only way to truly alleviate hunger is to resolve those underlying problems, the report's authors argued.

Douglas Kilama of Canadian Physicians for Aid and Relief's Ugandan operation noted that it's often the case that food aid coming from donor countries is far more costly than food that is available in recipient countries, yet agencies have often declined to buy locally.

Some relief agencies have advocated that aid should come earlier and in the form of cash, so that the hungry can buy their food locally and thereby, boost local markets. Such assistance would have to come well before the local food shortage reaches emergency levels. Yet, aid money spent on agriculture to sub-Saharan Africa has declined by 43% between 1990–92 and 2000–02.

"It is a disgrace that money is still given too late and for such short periods, then spent on the wrong things to truly fight emergencies," said Geoffrey Dennis, head of CARE International UK. "There is no excuse, when by spending money more intelligently, we can bring an end to all but the most unpredictable food crises."

While Ethiopia has been in food crisis 93% of the time from 1986 to 2004,

Evelyn Hockstein/CARE Canada

In addition to funding for crises, such as Darfur, CARE says more emphasis is needed on long-term development.