



**National Association of State Mental Health Program Directors  
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## **Assessment #5**

# **Being Seen! : Establishing Deaf to Deaf Peer Support Services and Training**

**November 10, 2015**

*This work was developed under Task 2.1.1. of NASMHPD's Technical Assistance Coalition contract/task order, HHSS28342001T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.*



## BEING SEEN !

Establishing Deaf to Deaf

Peer Support Services and Training

*Successes and Lessons Learned*

*From the Massachusetts Experience*

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The Hearing World exists side by side with the Deaf World. Hearing people lead busy lives, often not noticing a vibrant and distinct Deaf Culture that is in view. Deaf, on the other hand, are acutely aware of Hearing Culture; Deaf must accommodate it, or avoid it, or invest tremendous effort to be seen.

The fine grain of the Deaf Community is full of rich language, culture and historical nuance. While it is common to see the term “Deaf and Hard of Hearing services” and the abbreviations “(DHoH) or (D/HH),” the experiences of people within this broad term represent very different, and only sometimes overlapping, universes of communication and social connections. All the same, Hard of Hearing people, late deafened people, Deaf, and Deaf/Blind people are potent resources to each other in the community and in emerging Deaf and Hard of Hearing mental health peer support. For this paper the term “Deaf and Hard of Hearing Communities” represents this continuum of experiences. “Deaf to Deaf peer support” represents peer support for this continuum.

*“The ASL sign near the ear means ‘can hear’ or ‘listen.’ I encountered this sign used in a different way once - a way that moved me deeply. A man used the ‘can hear’ sign, but he used it at his chest, touching his heart, not his ear. You can feel how different that is. I felt I had been heard and understood deeply, in his heart. It seems to me like a beautiful way to communicate what we are trying to do with peer support.”*

While participants in shaping this paper were primarily Deaf, late deafened, and Hard of Hearing people, the team places high value on inclusion and addressing all communication barriers.

### **EMERGING PEER SUPPORT IN THE DEAF AND HARD OF HEARING COMMUNITIES**

Deaf to Deaf peer support services, within a context of Deaf and hearing stakeholders who are allies, create a bridge to mental health services and recovery, spanning both the communication and cultural divides. A number of local efforts in Deaf to Deaf peer support are gaining national attention. For example Minnesota developed a Deaf to Deaf Peer Specialist

Training based on the Appalachian Consulting Group<sup>ii</sup> curriculum. Deaf and Hard of Hearing peer recovery advocates from a number of states have led workshops at national conferences and policy events in the mental health recovery, trauma recovery, and Deaf and Hard of Hearing communities. These efforts in addition to the Deaf Community Voice Team experience in Massachusetts are building local and national support for this emerging voice.

## The Massachusetts Experience

The Massachusetts Department of Mental Health's commitment to Deaf and Hard of Hearing services has included establishing a Deaf Unit at a state hospital, hiring Deaf Case Managers, and purchasing Deaf-specific services such as outpatient, group home, respite and community based flexible support services. To increase communication access, they continue to partner with the Massachusetts Commission for the Deaf and Hard of Hearing for increased access to interpreters.

*“It is critical that we find a strong home and allies for Deaf and Hard of Hearing peer support and recovery. Deaf peers in mental health recovery are often seen as “other” whether in the natural community, deaf service agencies or within hearing mental health services. Peer support brings about community and provider education along with hope and recovery. It is worth the time and care and feeding that we invest.”*

The Massachusetts Department of Mental Health (DMH) also created a position to coordinate Deaf and Hard of Hearing services statewide, which was filled by a hearing person who also had a heartfelt connection to the Deaf and Hard of Hearing communities. As a certified interpreter, she was fluent in American Sign Language.

The Coordinator's tenure spanned several Commissioners, who all supported her leadership in initiating and sustaining collaboration around Deaf and Hard of Hearing services and mental health recovery in Massachusetts. These efforts included bringing about discussion about mental health recovery with Deaf and Hard of Hearing peer advocates. Four Deaf and Hard of Hearing peer leaders and an ally went to the 2006 national Breakout Conference<sup>iii</sup> for Deaf, Hard of Hearing and Deaf/Blind behavioral health service providers. It was called “Cultivating Recovery” where the image of recovery as a process of growth was deeply moving to the group.

The Massachusetts DMH also hired a Deaf peer advocate to do outreach, and to assist on a study about the viability of Deaf and Hard of Hearing peer support<sup>iv</sup>. The Department brought a small team of peer leaders, and Deaf Case Managers together to plan large regional meetings where Deaf and Hard of Hearing peer advocates shared their stories and invited their peers to discuss mental health recovery.

The Transformation Center, a statewide consumer network, participated in support of these events. With the assistance of the DMH Deaf Services coordinator and Deaf and Hard of Hearing peer leader pioneers, The Transformation Center was introduced to Deaf and Hard of Hearing cultures and the opportunity to become an ally. They hosted a Hearing and Deaf Leadership Academy out of which a series of training and peer support initiatives were begun. Key in this effort was the ongoing support of the Department, and the initiative of Deaf and Hard of Hearing leaders who joined The Transformation Center's governing board.

In subsequent Leadership Academy retreats it became clear that the hearing and Deaf people involved were excited about communicating and learning how to become allies. Shared experiences of suffering, healing, and laughter provided a foundation in relationships, and a focus on trauma informed peer support.

## **Factors in emerging leadership in the Massachusetts Deaf and Hard of Hearing Peer Community**

A number of key factors supported the emergence of Deaf and Hard of Hearing peer leaders in Massachusetts, including the following:

- Having experiences through traumainformed approaches that helped one to learn self-care, emotional resilience, and self-direction;
- Developing confidence in one's own mental health, trauma and substance use recovery;
- Developing and sustaining a few friends and allies in one's natural support community who gave supportive feedback;
- Engaging with a group of supportive and empowering stakeholders who believed in the value of Deaf to Deaf peer support, and understood the time it would take to develop peer support in a culturally appropriate manner;
- Engaging with the hearing peer support leadership to learn about the opportunities they have had, and to build ally relationships with them;
- Feeling personally ready to share one's story in the more public context of peer support services, and being personally ready to keep appropriate confidentiality with those one supports.

*“When I went back to the Deaf Unit at the state hospital after a few years, they had a new policy to prevent restraint and seclusion. They used ‘sensory techniques’ like weighted blankets, scents, playdough and other ways to enjoy the five senses. I learned that I could calm myself down by using different senses, by doing a hobby, or doing things I enjoyed as a child, like drawing. Each person learns new ways for themselves.”*

## **The Development of This Paper**

This paper provides key points and lessons learned on how State Mental Health Agencies can establish Deaf to Deaf Peer Support in their states and localities based on the experiences in Massachusetts. To prepare this paper, the Deaf Team Coordinator at the Transformation Center in Massachusetts reviewed interviews and recovery stories of all participants in the statewide Deaf peer support project, identified themes to explore further in a small number of interviews. The Deaf Team Coordinator worked with the Massachusetts Department of Mental Health and interviewed seven Deaf and Hard of Hearing Community leaders, two hearing peer coordinators, and held three focus group meetings to review and discuss themes and advice. The quotes in this paper come from the experiences shared during those interviews.

## **THE NEED FOR DEAF TO DEAF PEER SUPPORT NATIONWIDE**

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“I stayed for two weeks on the unit without speaking to anyone, and only spoke with a staff two times because interpreters were hardly ever there. For less than an hour each time! I didn’t know why they put me there or what the medications were for, and they wouldn’t explain. Everything I was struggling with continued, no change, except that I was lonely and confused every single day, hour after hour.”

“They were mad at me because I didn’t go to groups. They said ‘we know you can read lips!’ and then if I didn’t go they put me in seclusion. Who can lip read in a group? People don’t look directly at me, and the conversation moves around the room - by the time I see who is speaking there’s no way to catch up.”

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In the Deaf and Hard of Hearing communities, the need for mental health awareness and resilience is profound, and isolation creates exceptional vulnerability. Within the general Deaf and Hard of Hearing communities, recovery is not fully understood and discrimination against people with mental health conditions continues as in the hearing community. In addition, families of Deaf children frequently do not learn American Sign Language (ASL), so that even within the family, emotional resilience and connection is difficult to learn. Children with such communication gaps are 4 times more likely to be physically and sexually abused, and the prevalence of adults with serious mental illnesses is 3 to 5 times greater in the Deaf population than in the hearing population<sup>v</sup>. Deaf to Deaf peer support provides a context of trust and acceptance to support the recovery process with minimal communication barriers.

### **Peer Support Services as an Evidence-Based Practice**

The Centers for Medicare and Medicaid Services (CMS) recognizes peer support services as an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders.<sup>vi</sup>

Peer support specialists have a unique role in that they establish trust with service recipients through their shared experiences. A peer support specialist listens, educates, encourages and, in partnership with the service recipient, serves as a key voice in advocating for what is best for the service recipient’s recovery process. The research base also strongly suggests that the use of peer support services in state psychiatric hospitals and in the community shortens lengths of stays; decreases re- admissions; increases people’s engagement into care; improves community linkages; reduces substance use among people with co-occurring disorders; increases overall wellness and quality of life; and can help reduce the use of emergency departments and the overall need for mental health services in the long term.<sup>vii</sup>

Although peer support services and training have been expanding and are being established in the hearing community, the Deaf and Hard of Hearing communities have not had the same access and opportunities.

### **ACCESS TO TREATMENT IS VALUED BY DEAF AND HARD OF HEARING COMMUNITIES**

Peer support services are not a replacement for access to mental health treatment.<sup>viii</sup> Once aware of how helpful mental health services are when they are culturally and linguistically

appropriate, Deaf and Hard of Hearing people with mental health conditions want very much to use them.

The practice of trauma-informed care has been a tremendous asset to the recovery process of people who are Deaf and Hard of Hearing and have mental health conditions. State Mental Health Authorities have achieved system successes related to restraint and seclusion reduction and elimination. Through these trauma-informed efforts, the emphasis has been placed on communication, voice, choice, empathy, and sensory supports - all of which are components of overcoming communication barriers.

### **Culturally and Linguistically Appropriate Services and Environments**

Culturally and linguistically appropriate services and environments include:

- Trauma informed approaches that build on helpful treatment experiences and include rebuilding trust after treatment or institutionalization that may not have been helpful;
- Building understanding about mental health problems and how services and treatment can help;
- Building trust through experiences of communication access and comfortable crosscultural interaction in treatment settings;
- Clearly identified “go to” people who are allies;
- Understanding that mental health recovery is the goal and what mental health wellness can be like.

### **RECOVERY CONCEPTS IN THE DEAF AND HARD OF HEARING COMMUNITIES**

*“The conference used a flower image for ‘recovery.’ When a flower blooms from a bud, it opens up and secrets can be released. I blossomed, like a flower, when people told me their stories. Sharing secrets helps another person feel they are not alone. When I share about hearing voices, other people who have the same experience say ‘oh me too, I’m not alone!’”*

Recovery is not only taught, it is inspired. Recovery requires understanding on multiple levels within the person. Bringing Deaf and hearing people together for peer support, when communication access has been established, can inspire and educate both communities.

However these cross-cultural connections do not replace the important need of a Deaf or Hard of Hearing person to connect with people who share similar experiences around communication, language and culture.

The development of awareness about mental health problems, mental health services, and mental health recovery is a process where each person and community establishes concepts and language that make sense within the cultural context.

In Deaf culture, stories that illustrate experiences are of prime importance. When Deaf people meet for the first time, it is very common to begin by sharing one's background and what schools one went to. Stories from trusted people are the most influential, whether from a trusted treatment professional or family member, or a person with similar experiences. In the Deaf and Hard of Hearing cultures, stories verify the usefulness of ideas and information, and illustrate how the information can be used towards a desired outcome.

*“When we asked Deaf people who were receiving services from DMH what they knew about peer support, we realized people were familiar with the sign for peer when it was used for ‘peer pressure.’ We found that we had important discussions about the word peer, and how it is used in a positive way in ‘peer support.’”*

For the Deaf and Hard of Hearing communities, understanding the complex content within the concept of “mental health recovery” includes understanding the person-driven weaving of service-use, professional advice, and varied types of active self-development.

Learning about the recovery process within hearing peer support communities and mental health service cultures has expanded rapidly since the mid 80's. However, in the Deaf and Hard of Hearing communities, access to culturally appropriate mental health services and peer recovery examples have been limited. As a result, the understanding of mental health services and mental health recovery concepts are much less established in the Deaf and Hard of Hearing communities.

## **DEAF TO DEAF PEER SUPPORT AND TRAINING IS ESSENTIAL AND MOST EFFECTIVE**

Currently the Deaf and Hard of Hearing communities have little access to existing training, mentors, or mental health peer support environments. When a Deaf or Hard of Hearing person attends a training that is being provided in English with ASL interpretation, communication access issues and complexities may not be addressed.

*“When we needed a role play to demonstrate ‘peer support’ we decided to show two Deaf people, talking about how to handle a family party. Many of us grew up in families who didn't learn sign language. We could gesture about things, but you can't really talk about feelings or ideas. Being the one person left out in a group is a familiar kind of pain.”*

Hearing training formats and curriculum materials are not directly translatable linguistically or culturally for the Deaf and Hard of Hearing communities. Unlike in the hearing world, where information is conveyed with the written and spoken word or word-heavy PowerPoints, communication in the Deaf and Hard of Hearing communities often conveys concepts through sharing stories, experiences, and multiple examples, using pictures or visuals with few written words, role plays, facial expressions, and body posture.

## Deaf and Hard of Hearing: Language and Communication

There are variations of language use and proficiency in the Deaf and Hard of Hearing communities. Deaf community strengths include a sophisticated understanding of communication complexities and the desire to make sure people understand.

Many Deaf and Hard of Hearing people do not speak English fluently because it is a second language and even more do not read or write English proficiently. American Sign Language (ASL) is a distinct and separate language from English with grammar and nuanced concepts and idioms that do not translate directly into English and vice versa. Like all living languages, new vocabulary emerges over time, and regional “accents,” dialects and sub-culture slang all contribute to richness and specificity. Humor and subtlety are often culture-specific, creating a broader foundation for understanding and interpersonal connection.

Although some Deaf and Hard of Hearing people are comfortable with English, hearing people often make inadvertent errors based on a lack of knowledge that ASL is its own language and not English and that there are varying levels of understanding English in the Deaf and Hard of Hearing communities. Often hearing people assume that a Deaf or Hard of Hearing person has English fluency and will read and write notes in English and lip-read (rather than needing an interpreter).

It is important to know that lip-reading is exceptionally difficult. An excellent lip-reader may get only 30%<sup>ix</sup> of the words spoken because many words look similar on the lips. For example “twin” and “queen” look the same.

To add to this confusion, some Deaf and Hard of Hearing people are in fact very comfortable with English as their first or second language. For example, people who are “late-deafened” (deafened later in life after speaking English fluently) may continue to use English as their first spoken and written language.

During a training designed for the hearing community, Deaf and Hard of Hearing participants usually assist each other to understand the material and will try to accommodate differing communication needs; when this accommodation is occurring, the entire group of Deaf and Hard of Hearing involved may miss parts of the curriculum unless time is allotted for the process. Trainer understanding of the communication process is critical. Without that understanding, the Deaf and Hard of Hearing participants may appear less competent because building blocks of learning are missed. Also, aggression has been directed at Deaf and Hard of Hearing participants because their intergroup communication appears to

*“I was helping someone understand the ASL interpreters in the English training, but I kept missing some of the training while I was communicating with him. Almost all of the eight of us Deaf got involved. The other six Deaf got involved because when I missed some of the training, they would explain what I missed, and then I would keep explaining to the person I was helping, or sometimes another person would help him out. It was hard! We were laughing and joking too, to break the tension. That’s when the hearing trainer got upset with us for talking among ourselves.”*



be “crosstalk” or lack of interest.

By having Deaf to Deaf Peer Support Training, activities and communication needs are addressed and match the Deaf and Hard of Hearing cultures. Delays are accommodated as part of the culture and training agenda, participants’ learning needs are more likely to get met by having the training in their first language, and the quality of interactions significantly increase with more direct communication between the trainers and participants.

## **RECOMMENDATIONS FOR PROVIDING DEAF TO DEAF PEER SUPPORT TRAINING**

**Address Communication Complexities.** A key activity is to spend adequate time in advance of the training to ensure that the timeframe, agenda and number and type of interpreters will meet the particular communication needs of the participants who will be attending. While many Deaf and Hard of Hearing use ASL, others are not proficient in ASL and may need a Certified Deaf Interpreter (CDI) to ensure understanding. Also, a Deaf or Hard of Hearing person may have little overall language fluency related to early language deprivation. A CDI will interpret the ASL interpreters’ sign language with additional gestures that concretely depict abstract concepts, providing concrete examples or stories through visual communication. Some Deaf and Hard of Hearing are proficient in English (and may not be proficient in ASL) and prefer Communication Access Realtime Translation (CART) services projecting spoken words on a screen; while other Deaf and Hard of Hearing are most fluent with fingerspelling interpretation rather than strong ASL.

**Training activities should match Deaf and Hard of Hearing cultures.** Deaf Peer Support trainings should be provided through sharing stories, ensuring there is adequate time to socialize, building shared meaning, using small group experiential exercises, and using pictures or visuals with relatively few written words. Visual and expressive representation can also include role plays, games and poetry.

**Establish the concept and importance of confidentiality.** The Deaf and Hard of Hearing communities are small and often interconnected nationwide. Trust is often built through knowing people in common and sharing news. This interconnectedness is a strength of the Deaf and Hard of Hearing communities. However, similar to a rural context, Deaf and Hard of Hearing communities often face situations where there are dual relationships, and gossip or discrimination can be socially damaging for those who may have mental health conditions. To ensure that trust and an accepting environment is built, it is important to establish the concept and rule of confidentiality when providing Deaf Peer Support training and services.

**Establish Comfort Agreements at the beginning of trainings and peer support meetings.** Establishing comfort agreements provides the opportunity for participants to build consensus regarding what they need related to communication, seating arrangements, clarifying parameters of confidentiality, and any other support that facilitates participants in sharing as a group.

**Ensure there is shared understanding of the concepts of recovery, mutuality, trauma, wellness, and peer support.** The concepts of mental health recovery, peer support, and trauma are widely known in the hearing peer support community but are not widely known as

mental health concepts in the Deaf and Hard of Hearing communities. These concepts are often new paradigms. It is important to set the foundation for these mental health concepts in Deaf Peer Support training and in providing Deaf Peer Support. For example, the Deaf and Hard of Hearing communities have historically understood these words in the context of physical health such as recovery from a physical illness or physical trauma from a car accident, and “peer support” may evoke a negative response because of its association with the term “peer pressure”.

Much time needs to be spent in setting this foundation and the group needs to ensure that signs and communication are clearly agreed upon for expressing these concepts. One of the best ways to get across concepts is to match the lived experience to signs and expression through storytelling.

## **RECOMMENDATIONS FOR MIXED DEAF AND HEARING PEER SUPPORT TRAININGS**

It is important to note that there is value to cross-cultural training and people who are Deaf and Hard of Hearing and want to become Peer Support Specialists should not be left out of hearing trainings while waiting for Deaf Peer Support trainings to be established.

While Deaf to Deaf Peer Support is most effective, having mixed trainings allows for the Deaf and hearing communities to learn from each other. In addition to the recommendations made for Deaf to Deaf Peer Support Trainings, the following recommendations and guidelines should be implemented in a mixed Deaf and hearing training to ensure inclusion.

**Communication Complexities should be addressed in the same way as Deaf to Deaf Peer Trainings and there should be adequate time for interpreter catch up.**

**Interpreters.** Interpreters who are trusted by participants and who observe the Registry of

Interpreters for the Deaf code of ethics<sup>x</sup> should be used. Deaf peer supporters will need time to teach new interpreters how to interpret mental health recovery concepts, including trauma, peer support, mutuality and empowerment. To ensure network development and communication among hearing and Deaf and Hard of Hearing peers, there should be interpreters available during lunch and other breaks in addition to the training times.

**Eyebreaks.** Eyebreaks for people who are Deaf and Hard of Hearing are a physical necessity. While the act of listening involves no muscles, watching ASL interpreters or CART services requires constant use of eye muscles. Looking away for a minute may result in substantial confusion or misunderstanding. If there are inadequate breaks, a Deaf or Hard of Hearing person will miss critical information.

*“It is really hard to be part of a class that is meant for Hearing people. But when I took the ATRIUM class, it was like waking up. I always thought the trauma I had was because I’m Deaf. But there were Hearing people in the class with the same problems! One of the trainers had been in the state hospital too. All of a sudden I saw new ways I could make things better.”*

**Ensure Deaf and Hard of Hearing participants can see interpreters.** Training agendas and activities should be assessed with Deaf and Hard of Hearing leaders and interpreters to ensure activities are appropriate and to secure the right number of interpreters. Prior to the training, the trainers should work with Deaf and Hard of Hearing leaders and the interpreters on how to position the room for each specific training activity to ensure that Deaf and Hard of Hearing participants can see the interpreters, and ideally other participants. For example having activities in a circle allows Deaf and Hard of Hearing participants to see both who is speaking and the interpreter.

**Communication rules.** It is important that each person have the chance to ask questions and participate in the dialogue. Examples of communication rules may include: one person speaks at a time, or using a “communication ball” where the person with the ball is the only one speaking. When trainings include both hearing and Deaf and Hard of Hearing people, frequent breaks in speaking are needed to provide adequate time for interpreters to complete each short segment.

*“We agreed that people would speak one at a time and face the Hard of Hearing participants, but everyone kept forgetting and finally I gave up.”*

Deaf and Hard of Hearing participants often assist each other to understand the material. When this accommodation and clarification is occurring, many Deaf will miss parts of the curriculum unless time is allotted for the process as well.

Further, hearing people often give cues when they are almost done speaking such as changes in their speaking volume or saying “and the last thing I want to say is...” Deaf and Hard of Hearing people using interpreters do not have these cues until it is too late to get in the conversation. Time is needed so that Deaf and Hard of Hearing participants have the chance to provide input and ask questions.

*“I was trying to be involved in the meeting, but interpretation is always a little behind. So when I added my input, the topic had moved on. A board member was irritated at me because he thought I was continually being disruptive. He asked that the chair keep the meeting on track.”*

Trainers should take responsibility to ensure that there is adequate time for processing the concepts, and that there is an equal chance for input and questions. The trainer should have participants use a communication ball and monitor that clear turn-taking is consistent throughout the training. Sometimes trainers can ask Deaf and Hard of Hearing participants for their opinions before hearing participants.

Hearing participants often have a difficult time tolerating this unusual style of presentation. Everyone benefits when trainers educate and invite hearing participants into the multicultural experience at the beginning of the training, engaging the group as a team that is working together to ensure a strong group connection. It is also often helpful for Deaf participants to take center stage and share about themselves and about Deaf culture, entertaining questions and inviting hearing participants to feel free to connect during breaks. Trainers may set up specific small group activities to break the ice

among Deaf and hearing participants to reduce the sense of distance and insecurity participants may experience.

**Notetaking.** A hearing person should be designated to take notes for all Deaf and Hard of Hearing participants. This noting taking is helpful because the Deaf and Hard of Hearing participants will be watching interpreters and participants. This is common in Deaf and Hard of Hearing meetings and trainings as well, unless the training materials contain all the information delivered in the training.

## THE IMPORTANCE OF ALLIES

Experiences of exclusion of Deaf and Hard of Hearing people from a mixed hearing and Deaf and Hard of Hearing gathering is common and painful for the Deaf and Hard of Hearing participants. Unfortunately most hearing participants are unaware of this exclusion and pain. When a hearing person has not understood a Deaf or Hard of Hearing participant's culture and communication needs, sometimes aggression has been directed towards Deaf and Hard of Hearing peer participants.

*The trainer moved around while she spoke. But when we asked her not to walk in front of the interpreters she was aggravated and said 'no.'*

*"We had a staff meeting, but the interpreters couldn't be there, someone on the team whipped out a laptop and typed what was being said like CART services (but not as fast.) That way I could attend the meeting and not be excluded. We agreed we would all stop and eat together sometimes too. Otherwise I am always alone."*

Allies actively support the emerging voice of Deaf and Hard of Hearing peer support communities by being advocates and bridge-makers. Allies can be hearing, Deaf, service providers, family, community members, etc. and can help raise awareness and do many things to support access and inclusion. Recommendations for ally activity appear below in Recommendations for Allies.

## RECOMMENDATIONS FOR STATE MENTAL HEALTH AGENCIES TO DEVELOP DEAF TO DEAF PEER SUPPORT

Deaf and Hard of Hearing peer support cannot stand alone and should be promoted and integrated within the larger Deaf and Hard of Hearing Communities. To provide this integration, the following are recommendations for State Mental Health Commissioners/Directors and other State Mental Health Agency leadership:

- **Leadership is key.** Involvement and support from the State Mental Health Commissioner/Director is key to ensuring that the State Mental Health Agency addresses the recovery and communication needs of people who are Deaf and Hard of Hearing and

have mental health conditions. Part of addressing these recovery and communication needs includes establishing Deaf Peer Support.

- **State Mental Health Commissioner/Director should fund or obtain support for funding Deaf to Deaf Peer Support Specialist training and employment for Deaf and Hard of Hearing Peer Support Specialists.**
- **Listen to and use input from Deaf and Hard of Hearing peer leaders regarding policy, practice, and evaluation.**
- **State Mental Health Commissioners/Directors and the overall agency should have a strong commitment to provide trauma-informed care, including preventing seclusion and restraint.**
- **Establish a process for sustainability.** State Mental Health Commissioner/Director leadership can often change and establishing ways to sustain efforts to build a Deaf and Hard of Hearing Peer Support Community are important. To assist with this sustainability, every State Mental Health Commissioner/Director should actively support the following:
  - **Hire and/or identify a full time Deaf and Hard of Hearing services coordinator.** The Deaf and Hard of Hearing services coordinator should be a Deaf or hearing person who has a strong understanding of Deaf and Hard of Hearing cultures, a strong and openminded understanding of peer support and recovery within clinical and community environments, and serves as an ally for the Deaf and Hard of Hearing communities.
  - **Take a team approach.** To ensure sustainability, this coordinator needs to work closely with a team consisting of people within and outside of the Department of Mental Health so that the knowledge base and expansive responsibilities are not dependent upon one person. This team could include the larger Deaf and Hard of Hearing communities, Deaf and Hard of Hearing service providers, the broader stakeholder community including providers and hearing peer leaders, and Deaf and Hard of Hearing peer leaders.
  - **The State Mental Health Commissioner/Director should actively support the Deaf and Hard of Hearing services coordinator and team to do the following:**
    - **Assist, promote, and support the establishment of a Deaf and Hard of Hearing Peer Support Community and Deaf to Deaf Peer Specialist Training** as part of accessing mental health services for the Deaf and Hard of Hearing Communities.
      - **Support the Deaf and Hard of Hearing peer community to address culture and communication needs and ensure inclusion.** This includes developing Deaf and Hard of Hearing peers as trainers.
    - **Serve as advisor, mentor, and resource** to the State Mental Health Agency and community leadership related to providing Deaf and Hard of Hearing mental health services and Deaf and Hard of Hearing Peer Support Services and Training.

- **Identify key stakeholders and entry points that serve the Deaf and Hard of Hearing Communities.** Examples of stakeholders and entry points could include Deaf Independent Living providers, Domestic Violence organizations, state commission on Deaf and Hard of Hearing, Deaf schools, Deaf Arts organizations, state rehabilitation commission, Deaf mental health case managers, and the larger interpreter community.
- **Establish an ongoing process for identifying Deaf and Hard of Hearing peer leaders.** This process could include nominations from the key stakeholders.
- **Build relationships with mental health and other service providers** to share about Deaf and Hard of Hearing mental health recovery, Deaf and Hard of Hearing peer support, cultures, and communication needs.
- **Build hearing and Deaf and Hard of Hearing community allies** for Deaf and Hard of Hearing mental health recovery and Deaf and Hard of Hearing peer support by regularly convening a collaborative group that includes the key stakeholders.
  - **Establish a consistent process for obtaining input from the Deaf and Hard of Hearing peers and allies.** Examples of this process could include gathering as a community regularly or an annual statewide Deaf mental health day.
- **Encourage and empower Deaf and Hard of Hearing peers to develop their own internal initiatives, mentoring, and ways to be seen.** Identifying funds to hire Deaf and Hard of Hearing consultants and peer coordinators is a part of this process.

## RECOMMENDATIONS FOR ALLIES

- **Approach interactions with curiosity and asking about culture, communication needs, and individual preferences.**
- **Support the Deaf and Hard of Hearing peer support communities to have a voice in how peer support training and peer support services are delivered.**
- **Assist in ensuring that communication rules and comfort agreements are discussed and followed during mixed hearing and Deaf and Hard of Hearing meetings.**
- **Strategize with Deaf and Hard of Hearing leaders on how to accomplish policy and community goals.**
- **Work with Deaf and Hard of Hearing peer leaders to engage the general hearing and Deaf and Hard of Hearing communities to develop inclusion.** Visual and expressive representation, such as role plays, poetry, and skits, can be used within the general Deaf and Hard of Hearing communities to stimulate conversations related to mental health conditions, trauma, mental health recovery, peer support, and other mental health recovery concepts.

These visual means can be a vibrant way for the hearing community to gain an understanding of visual communication in Deaf and Hard of Hearing cultures.

- **Assist in planning gatherings that focus on learning about Deaf and Hard of Hearing mental health recovery.**

## **RECOMMENDATIONS FOR THE LARGER DEAF AND HARD OF HEARING COMMUNITIES**

Deaf and Hard of Hearing access to Deaf to Deaf peer support requires Deaf and Hard of Hearing people with lived experience to pioneer that direction. Pioneering includes the willingness of individuals to “come out” with mental health conditions. With communities that are so small there is often little privacy, and the fear of being judged and shunned is high making it more difficult to open up and share about a mental health condition.

The following are recommendations for the larger Deaf and Hard of Hearing Communities to develop an environment of inclusion and acceptance related to people who are Deaf and Hard of Hearing and have a mental health condition:

- **Support community gatherings of Deaf and Hard of Hearing peers and inclusion.**
- **Become an ally of the Deaf and Hard of Hearing peer communities.**
- **Learn about mental health recovery concepts.**
- **Provide an environment of acceptance when someone within the Deaf and Hard and Hearing communities shares that they have a mental health condition.**

## **RECOMMENDATIONS FOR DEAF AND HARD OF HEARING PEER SUPPORT LEADERS**

Once established, Deaf and Hard of Hearing Peer Support Leaders will need their own support and opportunities for continued development in their roles. The following are recommendations for Deaf and Hard of Hearing peer leaders:

- **Meet regularly with each other to support each other, learn together, and plan fun activities together.**
- **Practice self-care.**
- **Help each other to practice skills needed for peer support, giving feedback to each other.**
- **Practice a Code of Ethics, respecting each person’s right to confidentiality. Discuss with other Deaf and Hard of Hearing Peer leader the needs of the community,**

**how to advocate for the community, and be allies to remove communication barriers.**

- **Work together to find and nurture allies to the overall mission of increasing access to Deaf to Deaf peer support and recovery.**

## **CONCLUSION**

Peer support services and mental health recovery concepts have largely been embraced in the hearing world. However, peer support and learning about mental health recovery concepts among the Deaf and Hard of Hearing communities has just begun to emerge and are not widely known. People who are Deaf and Hard of Hearing and have mental health conditions should have the same opportunities to have peer support services as their hearing counterparts and learn about mental health recovery concepts. These peer support services should be Deaf to Deaf, which can build trust and a healing connection, reducing the pain of isolation so familiar in the Deaf and Hard of Hearing communities.

Deaf and Hard of Hearing peers who have had the opportunity to learn about mental health recovery concepts report that it has been healing for them. This healing has inspired many Deaf and Hard of Hearing peers to want to help others with mental health conditions by becoming Deaf and Hard of Hearing Peer Support Specialists and Deaf and Hard of Hearing Peer leaders. These emerging Deaf and Hard of Hearing peer leaders should have the same opportunities for Peer Specialist Training as their hearing counterparts.

Using this paper and its recommendations as a guide, State Mental Health Commissioners/Directors should support the establishment of Deaf to Deaf Peer Support Training and Services in their states to significantly support the recovery process of the people they serve who are Deaf and Hard of Hearing and have mental health conditions.

<sup>i</sup> Diane Squires and Rachel Klein were the first Deaf advocates at The Transformation Center, building ally relationships as Board of Directors members that provided a foundation for the work described in this paper. <sup>ii</sup> [www.ACG.org](http://www.ACG.org). ACG trains peer specialists for certification and reimbursement by Medicaid and other payers. <sup>iii</sup> [www.adara.org](http://www.adara.org) The annual Breakout conference provides professional development and networking opportunities for behavioral health professionals, administrators, and allied professionals serving deaf, deafened, deaf-blind, and hard of hearing persons.

<sup>iv</sup> Perspectives of People Who Are Deaf and Hard of Hearing on Mental Health, Recovery, and Peer Support Cabral L, Muhr K, Savageau J. Springer Science+Business Media: New York 2012.

<sup>v</sup> Hamerdinger, S. & Murphy, D. (2000). Using the Deaf Community as an Alternative Treatment Strategy: Developing Deaf Treatment Foster Homes. JADARA 33(2), 26-41.

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Mass Commission for the Deaf and Hard of

Hearing. <http://www.mass.gov/eohhs/docs/mcdhh/savvy-guide.pdf> <sup>x</sup>

<http://www.rid.org/ethics/code-of-professional-conduct/>