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## Certified Peer Support Specialists: Advancing Peer Support Services in Deaf Mental Health Care

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### **Cover Page Footnote**

The author wishes to express gratitude to Alison Aubrecht, CPSS Program Supervisor, for reviewing an earlier draft and providing some valuable “gems” for this article.

Prior to 1980, the notion dominating the mental health delivery system was that people diagnosed with mental illnesses would not recover (Anthony, Cohen, & Farkas, 1990). Stabilizing them usually involved high doses of medication, long stays in the hospital, or years of being in supervised environments. This could have included staff-run day treatment programs that entertained these individuals with television, games, recreational activities, and trips (Powell, 2009). Powell (2009) sees this mindset and notion as “the old system,” and many of these beliefs can still be found in modern-day agencies and organizations. Such beliefs have often been a struggle for many to let go of.

In the early 1980s, a new movement in the mental health delivery system began to materialize. Dr. William Anthony, Director of the Center for Psychiatric Rehabilitation at Boston University, identified four key factors in enabling this change: (1) the writings of individuals with mental illness such as Judi Chamberlain (1978) and Patricia Deegan (1988), who shared their recovery stories with the public; (2) the longitudinal research that proved that recovery from mental illness was possible; (3) the emergence of the philosophy of psychosocial rehabilitation (Anthony, 1993); and (4) advances in psychotropic medications (Powell, 2009). By the 1990s, the notion of people recovering from their mental illness had gained traction across programs and organizations in the United States. Because of this, Anthony (1993) calls the 1990s the “Decade of Recovery.” Individuals and staff during this decade were beginning to believe in the concept of recovery and began to creatively and resourcefully bring this belief into a variety of environments and program settings.

Currently, the peer support movement is making significant progress toward supporting mental health recovery as an important element in the present-day mental health care delivery system. According to the Substance Abuse and Mental Health Services Administration

(SAMHSA) website, peer support promotes “a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential” (2004, p. 1). The Appalachian Consulting Group (2011) further defines peer support as “the act of people who have had similar experiences with mental illnesses giving each other encouragement, hope, assistance, guidance, and understanding that aids in recovery. It can be done anytime or anywhere when two or more peers are in a mutual, supportive relationship” (p. 3, Session 5 Module).

The 2011 Pillars of Peer Support Services Summit (Daniels et al., 2011) reported that historically, peer support has focused on mental health care from “the inside out” with a very limited connection to the overall mental health care systems. However, peer support has slowly worked from the “outside in” by building a base in the mental health and community services within the state systems (Daniels et al., 2011). The impact of peer support services is anticipated to be immense as mental health care systems continually evolve from long-term hospitalization to community-based treatment and peer-to-peer support.

### **What are Certified Peer Support Specialist Services?**

Certified Peer Support Specialist (CPSS) services are, broadly put, the delivery of peer support services by trained individuals who have personally experienced a mental illness or psychiatric diagnosis. These trained individuals provide counseling/support and advocacy services to peers based on their personal and direct experiences as consumers of mental health services. They also share their personal recovery stories on a regular basis with peers who are currently struggling with mental health issues. Peer support is centered on empowering individuals during their recovery journey by connecting them with others with the lived experience of mental health challenges. “Lived experience” is a popular term in the field of peer

support, describing the aspect of one's identity being linked to his or her personal experience of living with mental health challenges. In addition, a CPSS shares his or her personal journey so that peers might feel inspired to accomplish their own goals. Often the peer will become a teacher, too, and the mentoring relationship is mutually beneficial. A CPSS can serve as a tremendous ally in the mental health workforce, specifically in responding to the shortage of direct workers and in becoming key partners in rural areas (Daniels et al., 2011). Finally, CPSS is determined at the state level and is contingent on completing necessary training and the demonstration of core competencies in supporting others in the recovery process.

### **Key Functions of a CPSS**

The essential duties of a CPSS are to guide peers by (a) modeling wellness, (b) showing personal responsibility, (c) teaching self-advocacy, and (4) instilling hope through the sharing of one's own life and story. A CPSS generally has flexible parameters in how his/her role can be utilized in the provision of direct mental health services (Davidson, 2012; Fricks, 2005):

- Outreach (e.g., Assertive Community Treatment [ACT] team)
- Community engagement
- Case management
- Intervention (individual and group)
- Coaching
- Advocacy
- Social support (inpatient and outpatient)
- Sharing resources to initiate and maintain recovery

## **The Evidence Base for Peer Support Services**

There is an emerging evidence base for peer support services in the general literature. More specifically, Daniels et al. (2012) reports that first-generation studies showed that it was feasible to hire people in recovery to serve as mental health staff; second-generation studies showed that peer staff could generate equivalent outcomes to non-peer staff in similar roles, and third-generation studies are investigating whether or not there are unique contributions that peer support providers can provide.

Dr. Matthew Chinman and six colleagues (2014) conducted a meta-analysis on published studies of peer support services 1995 to 2013. The meta-analysis concluded that peer support services achieved a moderate level of evidence for service effectiveness. More specifically, Chinman et al. (2014) noted, “Across the service types, improvements have been shown in the following outcomes: Reduced inpatient service use; improved relationship with providers; better engagement with care; higher levels of empowerment; higher levels of patient activation; and higher levels of hopefulness for recovery” (p. 439). Even so, the meta-analysis also noted some weaknesses in these studies and encouraged future research to be conducted with greater specificity, consistency, and rigor to help strengthen the evidence.

Clearly, there is a great need for empirical studies of peer support services in the Deaf community as advocated by Cabral, Muhr, and Savageau (2012). These authors state that more research is needed to assess how deaf and hard of hearing peers are faring with peer support services. In addition, one of the 34 research priorities developed by the National Association of State Mental Health Program Directors (NASMHPD) Consensus Planning Group in January 2012<sup>1</sup> was to evaluate the outcomes of peer support programs for deaf persons throughout the

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<sup>1</sup>[http://www.nasmhpd.org/sites/default/files/NASMHPD\\_Deaf\\_Mental\\_Health\\_Research\\_Priority\\_Consensus\\_Planing\\_Conference\\_34%20Priorities.pdf](http://www.nasmhpd.org/sites/default/files/NASMHPD_Deaf_Mental_Health_Research_Priority_Consensus_Planing_Conference_34%20Priorities.pdf)

United States. Interestingly, each of the 34 research ideas was ranked on its impact-feasibility for such a study, and deaf peer support was ranked as one of the highest<sup>2</sup>.

### **Reimbursement for CPSS Services**

In 2001, the services provided by CPSS became Medicaid-reimbursable (Fricks, 2005). Not all states have opted in, but at least 20 states can currently bill Medicaid (Daniels et al., 2010; Kaufman et al., 2012). The Center for Medicare and Medicaid Services (2007) recognizes peer support services as an evidence-based model of mental health care. This policy enabling reimbursement also established initial requirements for supervision, training, and care coordination, and stipulated that each state establish certification parameters (Daniels et al., 2012). For Medicaid reimbursement, peer support services must focus on identified treatment or recovery goals within the parameters of medical necessity (Centers for Medicaid and Medicare Services, 2007). The care coordination requirements made by the organizations must be also established and met (Daniels et al., 2009). The range for Medicaid reimbursement in the U.S. as of 2009 was between \$3 and \$19 per billable 15-minute increment (Daniels et al., 2009); these rates remain largely intact as of late 2015.

### **CPSS Code of Ethics and Professional Standards**

There is no national code of ethics that applies to all CPSS, although there are several versions available via Internet searches. Many states have their own CPSS code of ethics, and the InterNational Association of Peer Supporters has developed its own national practice guidelines (iNAPS, 2012) that have not been widely adopted in the United States. It is this author's opinion that the Peer Specialist Code of Ethics and Professional Standards developed by Northeast Behavioral Health Partnership (NBHP, 2012) is the best one to date. The NBHP's Code of Ethics has incorporated the CPSS code of ethics from four states, and includes five key domains: (1)

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<sup>2</sup>[http://www.nasmhpd.org/sites/default/files/Conference%20Summary%20and%20Results\\_0.pdf](http://www.nasmhpd.org/sites/default/files/Conference%20Summary%20and%20Results_0.pdf)

Consumer, (2) Self, (3) Colleagues, (4) Agency, and (5) Community. In its supplemental document, NBHP professional standards also comprise eight areas for CPSS to follow:

- Self-Knowledge and the Role of CPSS
- Ethics and Boundaries
- Cultural Awareness
- Advocacy and Ability to Locate Information
- Teamwork
- Consumer Choice and Empowerment
- Crisis and Safety
- Recovery

Thousands of peers have been trained and have worked in a wide variety of settings over the years, but questions remain regarding peer roles, responsibilities and values, especially given that no national standards have been uniformly adopted and enforced. Having a core set of standards is one important way to truly legitimize CPSS in the mental health delivery system.

### **Why Advance Peer Support in Deaf Mental Health Care?**

Cabral, Muhr, and Savageau (2012) share that public mental health delivery systems need to adapt and expand services for various cultural groups to ensure recovery. More specifically, there is a need for culturally affirmative peer support and recovery-oriented services in the Deaf community. The use of a CPSS as part of the treatment team has had a range of favorable results (Chinman et al., 2014; Daniels et al., 2009) results that are consistent in the Deaf community as evidenced by the author's experience in Minnesota. In addition, information provided by a CPSS is often seen as more credible to peers than that provided by mental health professionals (Woodhouse & Vincent, 2006). This supports Cabral et al.'s (2012) findings that many deaf



peers prefer to share their personal experiences with individuals they trust. Deaf peers also prefer that the provider needs to have an understanding of mental illness, which helps them feel less alone, especially in the presence of a mutually beneficial learning climate (Cabral et al., 2012). Deaf peers may choose to see a deaf CPSS first to gain better understanding of what mental health services entails before agreeing to see a trained mental health professional.

Working directly with a deaf CPSS or gaining awareness of the existence of a group of deaf CPSS can help reduce the stigma of mental health in the Deaf community. This stigma can be extensive, given how small the Deaf community is. Steinberg, Loew, & Sullivan (1999) explain,

“The social intimacy of the Deaf community, however, engenders concerns about confidentiality and privacy that limit deaf individuals’ willingness to share information about mental health service use with other deaf people. Keeping information about one’s mental health care private, which the hearing majority tends to take granted, is difficult in the small, intimate Deaf Community.” (p. 34)

The recurrent presence of deaf CPSS in the Deaf community can gradually help erase this stigma of mental health among its members. Deaf CPSS can also share their experiences through various platforms<sup>3</sup> and make positive public statements in order to instill greater public understanding about mental health issues in the Deaf community.

Steinberg et al. (1999) also found that the individuals in the Deaf community tend to utilize non-professional resources for mental health services, such as talking with deaf friends who are good listeners or with another deaf person struggling with similar issues (e.g., alcoholism or mental illness). Boundaries can easily blur when these individuals’ paths cross. A trained deaf CPSS who is ethically mandated to maintain confidentiality, establish healthy

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<sup>3</sup> Platforms may include public presentations, social media outlets, video clips, or other communication venues.

boundaries in order to reduce the risk of dual relationships, and avoid conflicts of interest, can instill confidence in deaf people that peer support services have the potential of being a welcome provision of direct services in deaf mental health care.

Establishing a cohort of well-trained CPSS is critical to addressing unmet mental health needs in the Deaf community and adding emerging interventions in the spectrum of deaf mental health care. Many states do not have mental health professionals fluent in American Sign Language (ASL) available. While a CPSS does not replace a licensed mental health professional, s/he can help to fill a gap in mental health services in the Deaf community. Furthermore, peer support services in deaf mental health care can benefit peers on issues related to deaf people, communication barriers, or coping with hearing providers' lack of sensitivity or understanding (Gournaris, Hamerdinger, & Williams, 2013). Advocacy and community support are other major areas of need in the Deaf community, and a CPSS can provide both. Finally, a deaf peer becoming a CPSS or a deaf peer working with a deaf CPSS can be very empowering for both individuals as indicated in Marco Gonzalez's story in Anderson, Glickman, Mistler and Gonzalez's 2015 article as well as the short videos<sup>4</sup> produced by the Massachusetts Department of Mental Health. These high-quality videos describe the value of peer support in the Deaf community, and several deaf peers in the videos also share powerful stories about their recovery experiences. Most of the deaf peers filmed in this video have completed the peer support specialist training.

### **Training Curricula**

There are several peer support services training programs and curricula across the United States teaching individuals in recovery to become peer support specialists. After these individuals complete intensive training and pass the competency tests they become Certified Peer

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<sup>4</sup><https://www.youtube.com/playlist?list=PLGB0oZ9YOLGfDqFs7zikt-YQzAK9nJMII>

Support Specialists and are then able to seek employment providing recovery education and peer support in various community mental health programs or organizations. Current known training providers include (the list is not exhaustive):

- Appalachian Consulting Group
- Consumers as Providers Training Program
- Depression Bipolar Support Alliance
- Institute for Recovery & Community Integration
- Recovery Innovations
- Recover Resources

However, the available training curricula are not designed to accommodate the unique training needs of peers who are deaf and whose preferred language is ASL, nor are they able to capture the unique lived experiences of this community. There are only a handful of deaf individuals who have undergone peer support services training despite the increased attention to peer support services at the national level. Furthermore, this pioneering group of CPSS has had the added burden of trying to fit peers who are deaf into existing training programs—which meant these individuals had to endure a minimum of five days of *ASL-interpreted* training. Not only that, as part of the training curriculum, they also had to interact with hearing peers during groups and breakout sessions. During that time, they were expected to share their thoughts, feelings, and recovery stories with their hearing peers and some deaf peers expressed that they often felt out of place, having had different experiences. Some deaf peers did not pass the exams to become a CPSS due to missing much information as a result of the interpreting process, instead of having direct access during the training. Considering the cultural issues of this population, a specialized curriculum that trains deaf individuals who are in recovery must be

delivered primarily in ASL. This adapted curriculum would offer an alternative in best practices for training peer support specialists with peers who are deaf.

The Appalachian Consulting Group (ACG) gave permission to the Minnesota Department of Human Services, Deaf and Hard of Hearing Services Division (DHHSD) to adapt its peer support training curriculum and training materials into ASL. In order to maximize this opportunity, DHHSD posted a request for proposals in 2012 from qualified responders to adapt the ACG curriculum into ASL and written English. The goal was to include English-captioned videos in ASL. The course modules and its materials included English text for the purpose of providing the information in another format. The ultimate goal of this curriculum was to establish a national training for peers who are deaf with psychiatric diagnoses and currently in recovery to become CPSS. It was believed that an ASL curriculum would benefit this group because in that the curriculum would be customized to fit their needs, language, and learning styles - a culturally affirmative curriculum that uses relevant deaf-related materials and research including recovery stories from deaf individuals. Another goal of this approach was to provide an opportunity for deaf participants to create a network of other deaf Certified Peer Support Specialists.

In June 2012, ZenMation, a Minneapolis-based multimedia company, was awarded a \$36,500 grant to adapt the existing ACG curriculum into ASL. A two-day instructional design task force meeting led by ZenMation and DHHSD took place on September 17 and 18, 2012, in St. Paul. Since this adapted curriculum was modeled after the ACG training curriculum, the purpose of this task force meeting was to preserve ACG's training model and adapt it into a culturally affirmative curriculum. This task force meeting also helped determine how a blended learning approach could be implemented, including the decision of which materials to keep, add

to, or adapt. Deciding which training components to translate into ASL videos was also deliberated. The blended learning approach consisted of a combination of ASL videos, readings, and group discussions with a live facilitator. Upon the completion of this training, participants would be eligible to test for certification in their own states, if required.

Numerous individuals were invited to participate in this two-day instructional design session, including two deaf CPSS from other states. The two deaf CPSS not only shared their experiences of experiencing an all-hearing ACG training, but were also filmed telling their recovery stories for use in the curriculum. This curriculum, named the Deaf Certified Peer Support Specialist (DCPSS) Training, was completed in September 2013.

Since developing the DCPSS Training curriculum, 23 individuals who are deaf, deafblind, and hard of hearing from seven different states have been trained (Aubrecht, 2015). The first two training classes took place in St. Paul in January 2014 and July 2014, and the third training class took place in Shrewsbury, Massachusetts, in May 2015. All of the peers passed the exam on their first attempt, proving that the ASL-based curriculum is culturally and linguistically affirmative.

Many peers completing the DCPSS Training have gone on to work in some capacity as peer support specialists (Aubrecht, 2015). The exact scope of their services varies, but the central aspect is meeting with peers struggling with mental health challenges, and providing support in identifying resources, mentoring, and modeling through their own recovery stories.

### **How Many Deaf Peer Support Specialists Do We Have in the United States?**

Peer support services often manifest themselves through a variety of job titles: Peer Support Specialist, Peer Supporter, Recovery Support Specialist, Peer Specialist, Recovery Service Specialist, Peer Recovery Support Specialist, Certified Peer Specialist, and Certified

Peer Support Specialist. The Peer Support Specialist and Certified Peer Support Specialist titles are the most common to date.

Both InterNational Association of Peer Supporters and Appalachian Consulting Group (personal communications, September 25, 2015) estimate that there are approximately 12,000 to 15,000 peer support specialists in the United States. The range of peer support specialists employed in the states varied widely from a low of 9 in Wyoming to a high of 500 in Pennsylvania (Daniels et al., 2009). As of late 2015, based on this author’s professional network, an estimated 41 peers who are deaf, deafblind, and hard of hearing from 13 states have completed formal training in peer support services. Several individuals have gone through training with interpreters, but have not been certified, while others are certified, but work in other professions. To date, Minnesota has trained 23 out of the aforementioned 41 peers nationwide using its ASL-based curriculum. Table 1 provides further data on known deaf peer support specialists in the United States.

<b>Table 1: Number of Deaf Peer Support Specialists in the United States</b>	
<b>State</b>	<b>Deaf Peer Support Specialists</b>
Arizona	2
Alabama	2
California	1
Georgia	3
Indiana	1
Kentucky	1
Massachusetts	9
Minnesota	7

Missouri	1
North Carolina	2
South Carolina	5
Pennsylvania	5
Wisconsin	2
<b>Total</b>	<b>41</b>

### **Minnesota's Deaf CPSS Program**

**History.** The South Carolina Department of Mental Health's Deaf Peer Support Program is a pioneering program in the provision of peer support services to the Deaf community. Inspired by South Carolina's work, the Minnesota DHHS issued a request for proposals in March 2013 to establish a statewide Deaf Certified Peer Support Specialist Services (DCPSS) Program. The initial proposals received did not meet the desired deliverables and work plans set forth in the proposal requirements. To remedy the situation, DHHS issued another call for proposals in October 2013 from qualified responders to function as a fiscal support entity for administration of the grant funding. As a fiscal support entity, the selected organization would also function as a payroll agent, employer of record, purchaser of goods, and other services when needed. Consumer Directions, Inc., of St. Joseph, MN was selected for an award of approximately \$80,000 per fiscal year, with DHHS overseeing the operational aspect of the program. The Minnesota DCPSS Program was launched in March 2014.

**Model.** The DCPSS Program is operated by two organizations and a contracted part-time program supervisor, who is a deaf licensed mental health professional. DHHS handles the operational aspects, including the Deaf Certified Peer Support Specialist Training and its

certification process. Consumer Directions, Inc., as a fiscal support entity, manages the payroll of the CPSS and the program supervisor. The program supervisor is independently contracted by Consumer Directions to handle the DCPSS Program daily operations, including providing clinical supervision to the CPSS group. Although the DCPSS Program is run by multiple entities, this formula has worked well for Minnesota, provided that each role and duty are clearly defined and respected.

As of this writing, the DCPSS Program employs seven part-time deaf CPSS, all of who are closely supported by the program supervisor. The CPSS work in both major cities and rural areas, and via videophone when appropriate. Additionally, the CPSS group meets in-person three to four times a year for either training opportunities or group supervision. The program serves areas statewide as determined by DHHSD regions<sup>5</sup>. Three CPSS works in the seven-county metropolitan area surrounding Minneapolis/St. Paul, one covers Central Minnesota, one serves Southern Minnesota, one works in Northeast Minnesota, and one serves statewide via videophone. It is a program goal to train more deaf peers to become CPSS and to provide services in other regions. The DCPSS Program serves as an excellent augment to DHHSD's Mental Health Program and its mental health grantees, and uses the Results-Based Accountability model for its program evaluation and outcomes.

### **Programmatic Outcomes**

In 2008, the Minnesota Department of Human Services adopted the Results-Based Accountability model to measure program outcomes (McDevitt & Gournaris, 2015). The Results-Based Accountability model is a management outcome tool and the data is regularly collected and reported to address results (Friedman, 2005; Schilder, 1997). There are several

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<sup>5</sup><http://mn.gov/dhs/people-we-serve/adults/services/deaf-hard-of-hearing/contact-us/>



DCPSS Program outcome data that could be measured or evaluated through this model, as shown in Table 2.

<b>Table 2: Results-Based Accountability Project for the DCPSS Program</b>	
<b>How much did we do?</b>	<b>How well did we do it?</b>
# intakes completed	% peers satisfied with peer support services
# of peers being served in region	
# of contacts	% peers receiving services within 2-3 weeks of referral
# of hours of services rendered	
# of appointments kept	
# of appointments canceled	% peers very satisfied with peer support services
<b>Is anyone better off?</b>	
# of peers meeting or making good progress in their recovery plan goals	% of peers meeting or making good progress in their recovery plan goals
# of peers having better understanding of their psychiatric symptoms	% of peers in recovery % of peers satisfied with their lives
# of peers increasing their involvements in the community	% of peers with improved relationships with people % of peers with improved symptoms
# of peers agreeing to obtain treatment	% of peers with increased knowledge

from	about
mental health providers	community resources
# of peers obtaining employment	% of peers obtaining employment

The most important measure is the peers' progress in their recovery plan goals every six months. This outcome is an indicator of the impact of the CPSS-provided direct services. The DCPSS Program's individualized recovery plans were audited in Fiscal Year 2015 for the Results-Based Accountability Project, and the review showed that 83% of the 70 individualized recovery plan goals had either been achieved or were in good progress. In addition, 85% of the peers receiving services from the DCPSS Program either had completed or were making good progress with their individualized recovery plan goals.

Some providers and peers have shared stories regarding the impact of the DCPSS Program. The following is a small sampling of the positive programmatic outcomes:

- The DCPSS Program is most beneficial when peers are in crisis or experiencing an emotional breakdown. When working with a CPSS, the peers meeting this criteria proved to be more focused on goals and more connected with their respective CPSS, and attempted to work together to follow through on their mini-goals. The peers were reportedly able to stabilize faster, as well as rebound much quicker. Through this process, the CPSS provided their peers with stress management skills that would benefit them in the next crisis.

- A peer struggled with drug addiction, had recent crises, and experienced enormous stress. This peer worked closely with a CPSS and has been able to maintain sobriety as well as maintain employment.
- A peer recently encountered a high-stress incident that involved unexpectedly changing Personal Care Assistants (PCA)<sup>6</sup>. In addition, a family member wanted this peer to move to a different region. The CPSS worked closely with this peer on improving communication skills and finding ways to communicate with the family member. Additionally, supporting the peer in communicating with the PCA companies provided much needed training. As a result, this peer has shown a marked decrease in anxiety.
- Even when a peer is not in crisis, s/he still benefited from having peer support. Oftentimes, s/he was able to practice statements with the CPSS during meetings, which significantly helped. Having the CPSS there to talk to after the peers try new things also made a difference.
- Another peer was also stable because having someone to talk to about end-of-life issues and to reflect on health issues helped alleviate loneliness. This peer and the CPSS also explored ways to maximize the peer's budget/resources in order to increase opportunities for socialization.

## **Recommendations**

Based on experience in creating and maintaining a statewide culturally affirmative continuum of mental health delivery system in Minnesota, the provision of peer support specialist services is one of the instrumental components in Deaf mental health care. The

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<sup>6</sup> A personal care attendant (PCA) is defined by the Minnesota Department of Human Services as an individual providing assistance and support for persons with disabilities who are living independently in the community. PCA services are provided in the recipient's home or in the community.

following recommendations are based on Minnesota's experience in adapting the existing peer support specialist training curriculum into an ASL-based curriculum, along with the development and establishment of a statewide Deaf Certified Peer Support Specialist Program.

1. For many deaf peers, it would be very beneficial to take peer support specialists training with deaf cohorts led by deaf facilitators in lieu of sending them to all-hearing trainings with interpreters. Deaf peers reportedly feel much more comfortable being with their own peers during group discussions, as evidenced by deaf CPSS who attended all-hearing trainings stating they wished they could have gone to an all-deaf training.
2. It is critical for a deaf CPSS Program to thrive and to be successful. The organization selected to operate this distinctive program must be deeply committed to Deaf mental health care and peer support services. This cannot be emphasized enough.
3. Recruiting deaf peers to become CPSS often works best when persons in recovery are specifically targeted. Advertising the deaf peer support specialist training to the Deaf community may attract persons with no history of mental health challenges, since many have sought this training in order to land a job as a mental health worker—a very different role from a CPSS. If this training is advertised to the public, it is crucial to screen all applicants. One way to do this involves asking them about their recovery stories. In addition, recommendations or letters of support from a person familiar with the peer's mental health needs and his/her recovery must be part of the process. That person could be a counselor, psychotherapist, case manager, psychiatrist, social worker, church/temple leader, program manager, and/or mental health practitioner.
4. A deaf peer as a CPSS should not be hired solely based on hearing loss. The organization must focus on qualifications and excellent interpersonal skills.

5. Clear job expectations of a deaf CPSS are imperative in establishing parameters. A written position description that plainly delineates work responsibilities and expectations of a CPSS is beneficial. More importantly, frequent supervision with a licensed mental health professional, especially at the beginning of one's employment, can help to clarify the CPSS's overall role.
6. Expect to deal with potential role confusions with a newly hired deaf CPSS (*I am a staff* versus *I am a consumer* versus *I am a friend*). Oftentimes, a deaf CPSS is also a mental health services consumer elsewhere. Some have worked in the mental health field in a different work capacity and have become trapped in their former roles. In addition, a CPSS may feel the pressure of trying to direct or "do for" the peers or becoming a friend because of similar lived experiences. Supervision again can offer a valuable venue to elucidate the role of CPSS and in how they can be supportive of their peers while establishing appropriate relationship boundaries.
7. Deaf CPSS, like any other CPSS, may experience the occasional personal struggle with their own recovery. Steps should be in place to ensure that the CPSS can ask for help when needed and get back on track. Examples include openly discussing struggles in supervision, providing in-person group supervision opportunities, and ensuring that CPSS do not become overwhelmed with too many people in their caseload.
8. Be prepared to develop and provide a series of trainings to deaf CPSS that are tailored to them due to limited local educational opportunities for peer support specialists in general. National conferences for peer support specialists often provide excellent workshops, but they can be cost-prohibitive for many agencies.

9. The acceptance of a deaf CPSS at other mental health organizations, or by various providers, and the skepticism of the recovery concepts as well as the value of CPSS Services can be challenging. Some organizations are risk-averse and do not fully understand what CPSS services entail. Education about the role of a CPSS and getting support from other organizations, providers, and decision-makers with emerging evidence of CPSS services can help alleviate this resistance. Consider including a deaf CPSS at team conferences, treatment planning meetings, or wraparound consultations, and treat this individual as part of the mental health team. This will help slowly change others' perspectives and attitudes about CPSS.
10. Conversely, some providers or organizations may be too zealous in referring deaf peers for CPSS services in order to reduce their workload or to quickly close their cases. Some deaf peers are not ready or motivated to work with a deaf CPSS. Establishing an appropriate referral system and maintaining realistic criteria in accepting referrals is necessary.
11. Establishing and maintaining a deaf CPSS program can be a financial challenge for some organizations. Creative thinking about funding streams is necessary. Actively seek grants through federal programs, the state, counties, and private foundations. Attempt to utilize Medicaid reimbursement when appropriate, but do not plan to rely on this as a primary source of revenue.
12. Establish and maintain an effective working relationship with a qualified network of state-level mental health professionals and other providers who work with individuals who are deaf and have mental health challenges. This ensures all involved parties collaboratively develop and implement an individualized plan of care for each peer,

which will have a profound impact on recovery. More importantly, all involved parties must consider each individualized plan of care as peer-driven, not staff-driven. That said, peers should formulate their own recovery goals and plans of care as much as possible.

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