Mental Health First Aid™ for Deaf communities: responses to a lack of national Deaf mental health service provision

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Abstract:

Purpose: For over fifteen years Mental Health First Aid™ (MHFA) has successfully been delivered in Wales, UK, with growing interest in the MHFA programme and increasing course attendees. Trainers, aware of the need for support, know the importance of MHFA being accessible for different communities and learner groups. MHFA has always focused on increasing mental health literacy. One marginalised group, with lower mental health literacy than general populations, are Deaf people, a group with increased risk of mental health problems. In this article we provide insights about why Deaf people are twice as likely as hearing people to experience mental health problems.

Approach: During this paper we have used four focal points i) exploring situational contexts for Deaf people; ii) reasons why Deaf individuals are at greater risk of mental health problems; iii) we explore a project, *'Hear Deaf'*, and implementation of MHFA Wales by Deaf MHFA trainers; and iv) initiatives to influence and impact on policy makers.

Findings: During the project, nine MHFA courses were delivered to Deaf communities across different locations in Wales, often with information and advertisements circulated direct to Deaf communities through Deaf clubs, resulting in 120 Deaf people trained. We conclude with our own reflections as a researcher and a Mental Health First Aid trainer who work predominantly with Deaf communities.

Originality: This paper provides discussion on the specific risks for Deaf people around mental health and the importance of mental health promotion programs for Deaf communities. Further research is needed regarding the impact of MHFA on Deaf populations.

Keywords: Mental Health First Aid, Deaf, mental health promotion, mental health literacy, British Sign Language, BSL

In this paper we are using the term Deaf with a capital D as an all-inclusive term to include those who identify as culturally Deaf, who may use a Signed language, as well as those who are hard of hearing.

Introduction

The Mental Health First Aid™ program (Mental Health First Aid International, 2024) was introduced to the UK initially in 2002 in Scotland, followed by other UK countries, and finally to Wales in 2008 (Terry, 2009). At the time of writing, in Wales there are currently 261 active MHFA instructors, with over 1400 MHFA Wales face to face courses delivered between 2019 and 2023, as well as 1600 MHFA Wales courses that have run online.

MHFA England has been established for over 15 years now, with an aim to train one in ten people in MHFA England across the population, currently they have achieved one in 45, with over 20,000 organisations trained (MHFA England, 2022). As mental health problems cost the UK economy between £70 billion and £100 billion annually and account for around 15.8 million working days being lost per year there has been an increasing focus on the delivery of mental health promotion programs in the workplace (Narayanasamy et al., 2018). Studies have shown that workplace mental health training needs to ensure diverse and inclusive understandings of mental health (O'Gorman, 2020) in order to be current and accessible.

The MHFA programme was developed with the potential to positively impact on the mental health of whole populations (MHFA International, 2023; Terry, 2009), and with a program that has now become global over 25 years, with MHFA continuing to demonstrate its effectiveness in at least 24 countries (MHFA International, 2023). As well as the Standard MHFA course for adults, there are specialized courses for various cultural and professional groups, tertiary students, financial counsellors, and pharmacists (Morgan et al., 2018). Courses may also be adapted to ensure cultural relevance, for example the Youth MHFA adapted from the teen Australian version, to be delivered to US teens (Rosenbaum et al., 2023). MHFA has increasingly been utilised to promote mental health with communities at increased risk of mental health problems requiring culturally appropriate expert consensus guidelines on how to provide MHFA courses, for example to Australian Aboriginal and Torres Strait

Islander persons (Armstrong et al., 2018), and also to Deaf communities (Ferndale et al., 2022). It is essential that diversity, equity, inclusion, and belonging are incorporated into MHFA programs to ensure relevance, accessibility, and respect (National Council for Mental Wellbeing, 2023).

There is increasing evidence that Deaf and hard of hearing people experience twice the risk of mental health problems than hearing people (Dreyzehner & Goldberg, 2019; Glickman et al., 2020). Deaf communities also have lower levels of health literacy than hearing populations. According to McKee et al (2015a), Deaf individuals are 6.9 times more likely than hearing participants to have inadequate health literacy. Subsequently people who are Deaf are likely to be disadvantaged in accessing health information and also experience increased anxiety at the challenges experienced arranging health service appointments due to limited accessibility (Foltz & Shank, 2020). Barriers in accessing helplines and delays mean treatment can come too late, putting people at risk of suicide (Fontanella et al, 2020) When someone is seeking help, particularly for the first time, barriers to care may have tragic consequences.

This paper is structured around four key points. In the first point we explore situational contexts for Deaf people, including a brief overview of the impacts of Deafness. In the second point we focus on reasons why Deaf individuals are at greater risk of mental health problems, including likelihood of trauma and increased vulnerability. In the third point we examine a project, '*Hear Deaf Mental Health in Wales' (*BSMHD, 2020a*),* and how implementation of MHFA Wales by MHFA trainers who were Deaf themselves delivered the program to Deaf communities across Wales, UK. In the fourth point we discuss further initiatives to influence and impact on policy makers to make tangible changes to Deaf mental health provision. This paper offers an updated commentary on the current status of mental health provision and needs for Deaf people in Wales

Prevalence of Deafness and language development for Deaf children

Currently over 1.5 billion people live with hearing loss, which is equivalent to nearly 20% of the global population; and by 2050 it is expected that there could be over 700 million people worldwide with disabling hearing loss (World Health Organisation, 2023a). Approximately 70 million Deaf people across the globe use a signed language to communicate (United Nations, 2023), with over 300 sign languages worldwide (Pylkkänen, 2019). In Wales, UK there are around 575,000 Deaf and hard of hearing people (Action on Hearing Loss, 2015), and this includes over 4000 people who use British Sign Language (BSL) (Shank & Foltz, 2019).

More than 90% of Deaf children are born to hearing parents who have no previous experience of Deafness, meaning Deaf children are often born into worlds with few Deaf role models (Terry et al, 2021). Hearing families are reliant on advice and information from health professionals (who may be the first and only point of contact) are not always informed about the importance of early language development and ways they can help and communicate with their child from a very early age. Early communication is key, regardless of any later interventions and treatments. As hearing parents are not expecting to raise a Deaf child, it is important that families benefit from a range of support processes and interventions to support them (Humphries et al., 2019). Deaf parents tend to fare better as they have access to communication, role models, immediate integration into Deaf communities and role models for visual cues and language learning (Brooks, 2020).

Due a range of reasons including limited programs and funding support for hearing parents to learn sign language, Deaf children tend to experience language deprivation compared to hearing children, and subsequently under-perform in education settings with many widely acknowledged to have severe reading and

language delays (Herman, 2019). Research suggests that Deaf people are more likely to leave compulsory education with fewer qualifications and are less likely to transition to further or higher education than hearing people (Maher, 2021). Reasons for fewer qualifications compared to hearing counterparts often relate to language acquisition which has been described as the primary emergency of Deaf children (Hecht, 2020). According to Gulati (2018) Language Deprivation Syndrome is a permanent, life-altering, and preventable disability and although it rarely occurs in hearing people, it is epidemic in the Deaf population, and whilst this language deprivation begins in childhood the impacts can be life-long. Adverse Childhood Experiences (ACEs) are poorly characterised for Deaf populations, meaning early interventions and health policies should consider interventions to support healthy environments for deaf children (Hall et al, 2023).

Reasons why Deaf people experience increased mental health problems compared to hearing populations

In the 21st century there are increasing examples of highly educated Deaf communities with positive social identities that include the celebration of Deaf culture (Chapman, 2021). However, due to many Deaf children experiencing language delay, it is common that they have not been able to communicate their own concerns and feelings. Ultimately this leads to many Deaf people being isolated and consequently more vulnerable, as well as more at risk of harm. Examples of increased harm in comparison to hearing young people relate to bullying (Cheng et al, 2019) and exposure to interpersonal traumas such as physical, sexual, and emotional abuse (Schwenke, 2019). As Deaf children have increased likelihood of language delay, they may be less able to share and get support, so the risk of trauma is higher compared to hearing individuals. Considering the impacts of language delay, educational and employment issues often leading to low socio-economic status and isolation, as well as risk of trauma; this goes some way in

explaining why Deaf people experience twice the risk of mental health problems compared to hearing people (Pertz, 2018).

In everyday life Deaf people experience barriers and inequality of opportunity in several areas including education, employment, the criminal justice system, access to legal advice and in health services (Wilks, 2020). For example, Deaf people have much lower levels of health literacy compared to hearing people (NaseriBooriAbadi, 2021), due to limited accessible information, difficulties with appointment systems and on arrival at health facilities, as well as during treatment (James, 2022). Negative experiences in health services often lead to increased anxiety and dissatisfaction with health services and often lead to mental health problems (Schniedewind, 2020). Mackinnon (2016) highlighted that to achieve genuine equality of opportunity, positive measures are needed to ensure all persons share a genuinely equal chance of satisfying the criteria for access, and this requires resources, as well as accessibility measures and alternative facilities. Studies indicate that health services have far to go in terms of reaching anywhere near satisfactory levels for Deaf patients (Senayah, 2019; Panzer, 2020). The accumulation of inequality of opportunity and ongoing frustrations with limited accessibility to services, built on potential limitations relating to language development and education, go a long way in providing rationale for Deaf people's increased mental health problems compared to hearing populations.

As there are frequently reported poor experiences for Deaf people in health services, and the reasons for increased mental health problems in Deaf populations, it is also evident that the experiences of Deaf people in mental health services also need significant improvement (Myers and Danek, 2019). According to Gwaltney (2022), mental health treatment services are predominantly designed for hearing people, along with standardised tests which rarely consider aspects of Deafhood. Deafhood is a concept identified by Ladd (2003) which promotes the concept that a Deaf person is on a journey to discover their identity and purpose. Health professionals who are hearing will likely have limited understanding of the relevance of this

concept, and the unique linguistic accommodations required for Deaf patients may leave providers reluctant or unable to work with them (Gwaltney, 2022).

There are examples of mental health services specifically tailored to meet the needs of Deaf people in the UK (Wright, 2012; British Society for Mental Health and Deaf People, 2020a), and the US (Crowe, 2017; Pertz, 2018), however these are few and far between. Wales is the only UK country to have no Deaf mental health service provision (Terry et al., 2021). Population health is often best addressed through strategic approaches that include increasing health literacy, prevention, and promotion to empower at-risk populations. Therefore innovative and culturally relevant approaches to health improvement are needed.

Mental Health First Aid with Deaf communities in Wales, UK: the *Hear Deaf* project

Due to the lack of mental health service provision for Deaf people in Wales, despite lobbying to government, and anecdotal evidence of increasing suicides of Deaf people in Wales, it was the work of a Deaf charity, the British Society for Mental Health and Deaf People (BSMHD, 2020b) who applied for grant funding for the *Hear Deaf* project. Knowing the success of the international mental health promotion program (Jorm et al, 2019), BSMHD originally approached the MHFA Licence holder for Wales, which was Public Health Wales at that time, to carry out a pilot MHFA 2-day course for Deaf people in an area of North Wales prior to submitting a funding bid. Following the success of the pilot, *Training in Mind*, who had become the new MHFA Licence holder in Wales, to train four Deaf trainers to deliver MHFA to Deaf communities in Wales.

The trainers were mentored by an experienced MHF Aider based in England, who identifies as part of the Deaf community. A sustainable model was developed with

Deaf instructors reviewing MHFA resources. Training materials needed to be adapted with visual concepts of the impact of mental illness, along with figures and data. It was also essential to discuss principles of mental health with Deaf communities, as well as interventions in British Sign Language (BSL) along with activities and Deaf issues, and how they relate to the common issues experienced daily by Deaf individuals, and how to be more assertive in particular settings, such as health services.

Deaf MHFA trainers were not only able to empathise in their own cultural context, but also used the same language, and had the same Deaf roots background in terms of identities. This strong sense of belonging developed a rapport between learners and teachers through BSL. Additionally, the sensitivities and small communities of Deaf people brings risks of exposure regarding personal experiences, so trust is fundamental when bringing a group of Deaf learners together, to ensure they can be able to share, as well as conduct learning in a safe environment.

Deaf trainers delivered training to Deaf communities in pairs, which is recommended as co-training has been found to be important in terms of the logistics of delivering MHFA (Terry, 2011), particularly if participants required further support. During the project, nine MHFA courses were delivered to Deaf communities across different locations in Wales, often with information and advertisements circulated direct to Deaf communities through Deaf clubs, resulting in 120 Deaf people trained. A sustainable model was developed with the licence holder ensuring support, engagement and ongoing supervision. However, the end of funding prevents ongoing training beyond the *Hear Deaf* project which means the continuity of training is not possible unless this becomes a core funded activity. If health and care services and Welsh government were able to support further rollout of Deaf MHFA in Wales, this would go some way in enabling Deaf people to raise awareness of their own battles and health experiences in order for the Deaf community to have better access to services that support their mental health and well-being.

In addition to the training of Deaf instructors, the *Hear Deaf Mental Health in Wales* program was also supported with advocacy, outreach and practical workshops. The *Peer Deaf Mental Health Advocates*, who mostly worked with Deaf charities, helped to promote the MHFA courses in Deaf communities, and promoted the importance of early intervention. The Deaf advocates helped to support Deaf people with or facing mental health issues by signposting them to help, or assisting them to understand and explore self-help strategies on a Peer-to-Peer basis.

This is not the first time Deaf people have been involved in discussion and delivering of the MHFA program. Ferndale et al (2022) conducted an international Delphi study. A Delphi study involves a structured approach to obtaining consensus on a research question, with subject experts consulted who reflect and consider their view based on anonymised opinions of others. Ferndale used a Delphi expert consensus method to develop two sets of guidelines. The first, considerations for Deaf people providing mental health first aid to a Deaf person with a mental health problem. The second, considerations for hearing people providing mental health first aid to a Deaf person with a mental health problem (Ferndale, 2022). Statements were rated over three rounds by one diverse expert panel comprising 24 people, who were either Deaf or hearing, who were mental health professionals, interpreters and academics in Australia and overseas. A total of 433 statements were rated, with 290 statements endorsed by at least 90% of the panel. The resulting guidelines are the first that are specifically developed to assist Deaf people experiencing a mental health problem where Deaf people were involved in the research team, working group and as expert panellists. Resulting guidelines were used to inform policy and practice and to develop the MHFA course on how to assist Deaf people experiencing mental health problems. The intention is that guidelines will be translated into multiple sign languages and used around the world to train hearing and Deaf people in how to assist Deaf people in ways that benefit the person with mental health problems Ferndale et al., 2022). MHFA continues to offer participants and organisations an informative programme to skill up people to become Mental health first aiders

Initiatives to influence and impact on policy makers

Drawing attention to gaps in services that negatively impact on people's quality of life and outcomes is vital, and this prompted the writing of the *Deaf People Wales: Hidden Inequality* report (Terry et al, 2021). The All Wales Deaf Mental Health and Well-being Group are a collaboration of Deaf and hearing professionals who highlighted key recommendations including the need for basic training around Deaf issues for all health and care workers, an accessible mental health helpline and signposting service to direct individuals, families and workers to timely advice; and to monitor the effectiveness of Welsh Health Boards' delivery of All Wales Accessible information standards. It is vital that marginalised communities continue to inform governments of areas of unmet health need, particularly for at-risk communities. For example, Welsh Government set up a Disability Rights Taskforce to collaborate with Policy Leads, to work with people with lived experience and disabled people's organisations (Welsh Government, 2024).

Equally, government consultations are opportunities for groups and organisations to work together to lobby for change. Following a consultation on mental health inequalities in Wales, UK, the All Wales Deaf Mental Health and Well-being group submitted evidence resulting in a promise to review Deaf mental health provision in Wales in the *Connecting the Dots* report (Welsh Parliament, 2022), with outcomes still awaited, and consultations in progress regarding the next Welsh Mental health strategy.

In the US, the Mental Health First Aid Act (Congress, 2016) was a bill introduced in Congress to improve awareness, identification, and ability to appropriately respond to the needs of persons experiencing symptoms of mental disorders. The goal of this act is to provide mental health first aid training to first responders (Bhatta, 2018). As first responders are often first on the scene in an emergency, it is vital they have basic mental health training. Policy makers can really effect positive change here by supporting workers most likely to encounter people with mental health problems, and

it is widely acknowledged that due to poor access to health services, Deaf people do use emergency services more than hearing people (McKee et al., 2015b).

According to Erismann (2021), three key strategies were identified as fostering research uptake into policies and practices: First, stakeholders directly engaged with and sought evidence from researchers; second, stakeholders were involved in the design and throughout the implementation of research projects; and third, stakeholders engaged in participatory and transdisciplinary research approaches to coproduce knowledge and inform policy. Over the past decade much progress has been made translating mental health assessment tools into BSL, with guidance for use available (University of Manchester, 2024), with Deaf communities fully involved. Clearly there is a need for Deaf communities to be more involved in Deaf mental health research, as well as the design and development of mental health services.

Discussion

There is much to do before those who are Deaf have the same access to mental health services as people who hear (Vernon and Leigh, 2007). According to the World Health Organization (2023b) it is essential that health promotion methods and approaches, including mental health literacy programs, are planned, and delivered in the context of local customs and culture; in a language in which resources must be available. No easy feat for Deaf MHFA instructors delivering in a country without mental health service provision for Deaf communities. MHFA continues to bring a health literacy program that is adaptable to different populations and much success with delivery by members of defined population groups. Adaptability from program developers, licence holders, mentors and trainers themselves is key.

The World Health Organization (2022) includes early intervention as a key priority to promote actions to reduce suicide. Many people with mental health conditions do not

have access to effective care, because services and supports are not available, lack capacity, cannot be accessed or due to stigma; and misinformation may stop people from seeking help (World Health Organisation, 2022). For Deaf communities to have an accessible mental health literacy program delivered in their cultural context by members of the Deaf community is a triumph for mental health promotion, but we do know that health programs are best delivered by community stakeholders and are often essential to success.

Places where Deaf people are, particularly workplaces, justice systems and education providers, would all benefit from delivering accessible versions of MHFA. We know the demands of education and training, and access within those settings, can trigger mental health problems, just at point when a Deaf individual is pursuing study, or training to support employment, and needs enablement not added stress. Training providers need to consider delivery more broadly to meet the needs of staff and students alike. However in the absence of state provision and support, it is not uncommon to see communities and professionals working together creatively to find solutions to health issues, in the absence of support from health, care and education providers.

Reflections

In this paper we have provided context as to the history of MHFA in the UK. We then highlighted the increased risk of mental health problems for Deaf populations and how MHFA can be a useful platform to increase mental health literacy in Deaf communities, particularly when taught by Deaf MHFA trainers. There are clear messages to mental health policy makers, commissioners and health and care providers who should fund and develop mental health promotion interventions and mental health literacy programs, as well as training for staff to better support the mental health of all population groups. Further research is needed regarding the impact of MHFA on Deaf communities. Equally, when governments heed

recommendations from specific community groups at risk and do begin to look explicitly at mental health service provision and the communication of how and where Deaf people in Wales might access mental health support, it would be timely to explore the impacts on new provision on Deaf communities' mental health. Currently, without further funding and support, MHFA for Deaf communities in Wales is beyond delivery, because it is a matter of resource which sadly prevents further training from taking place.

3622 words

The first author continues to be involved in the All Wales Deaf Mental Health and Well-being Group, and the second author was a MHFAider with the Hear Deaf Mental Health in Wales project.

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