INTEGRATING PEERS INTO SUICIDE PREVENTION

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OUTLINE

- BLUF
- Scoping review
- Peer specialists in VA
- PEVAIL RCT and VA Pilot

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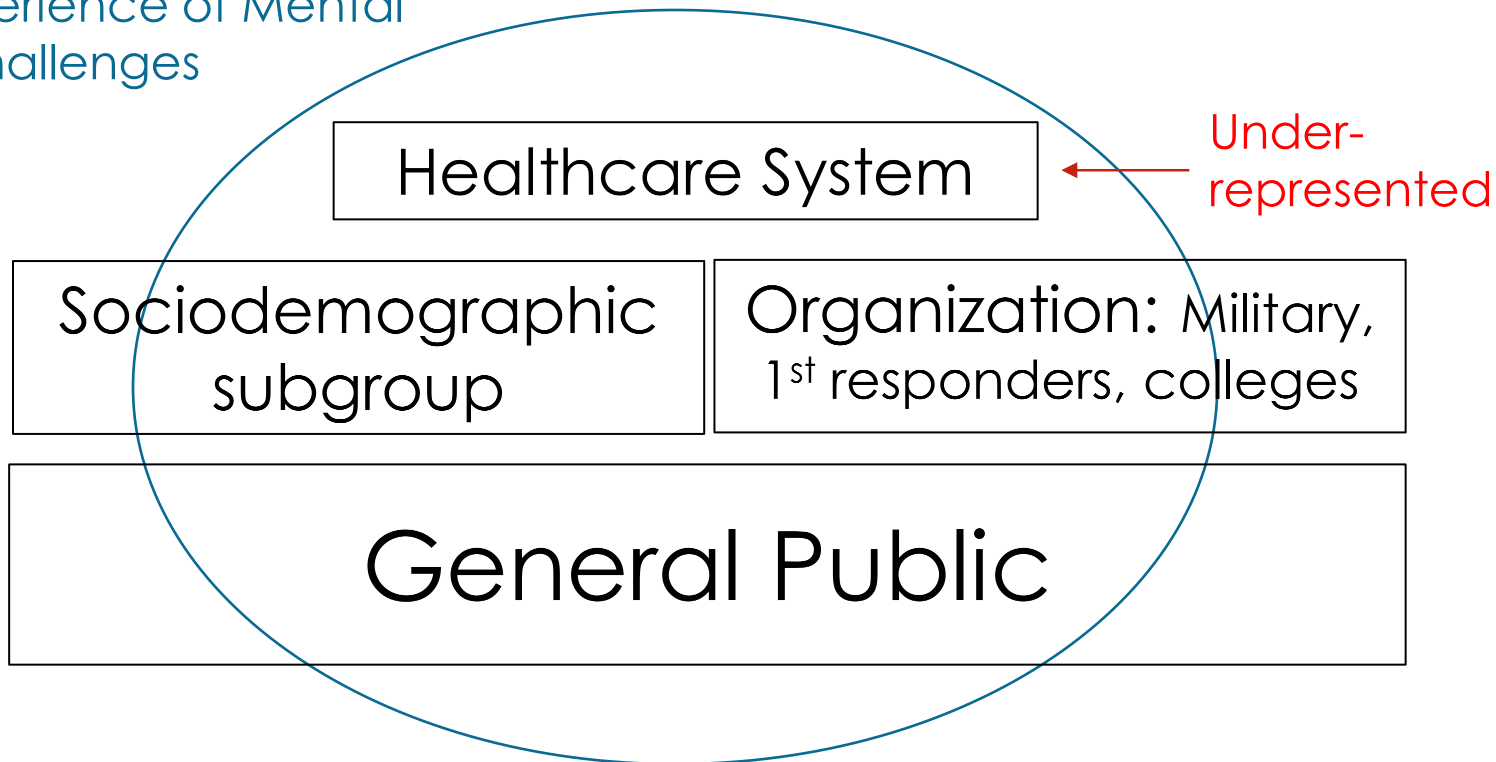
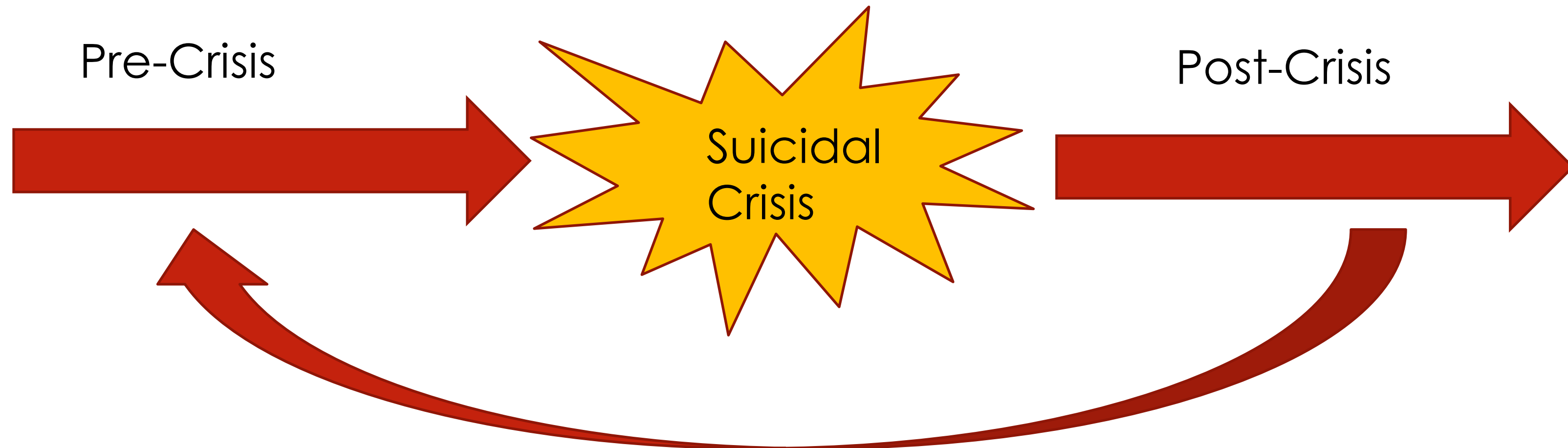
What is a peer?

Big Picture Sources of Peer-ness



Adapted from Bowersox, 2021

ROLES OF PEERS IN SUICIDE PREVENTION



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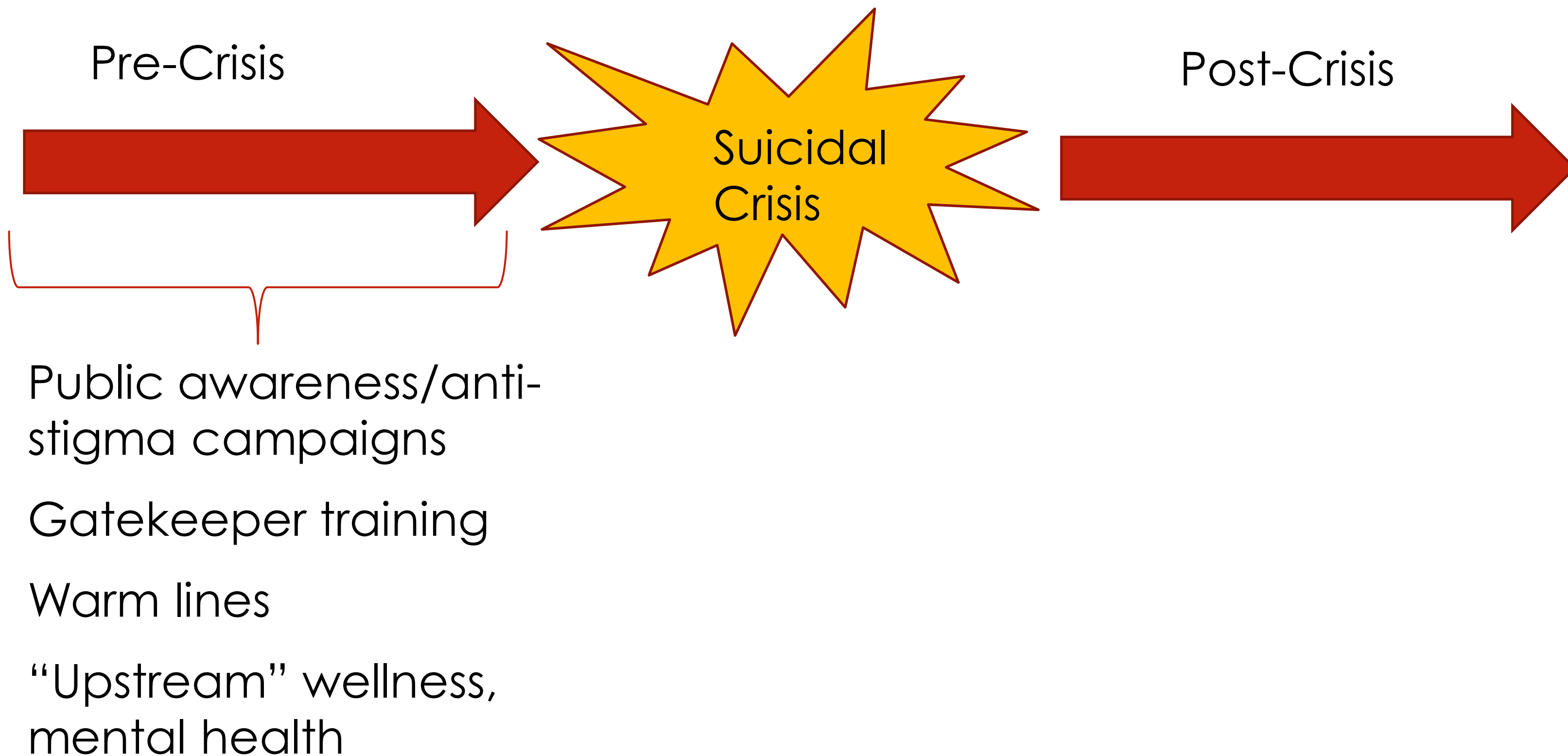

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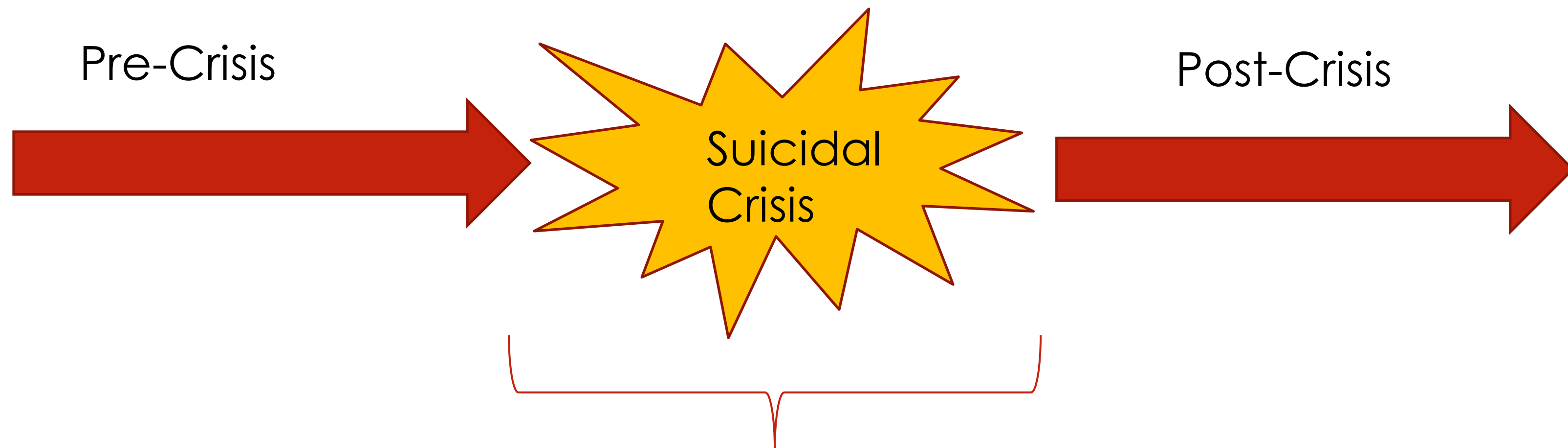


Crisis lines

Mobile crisis teams

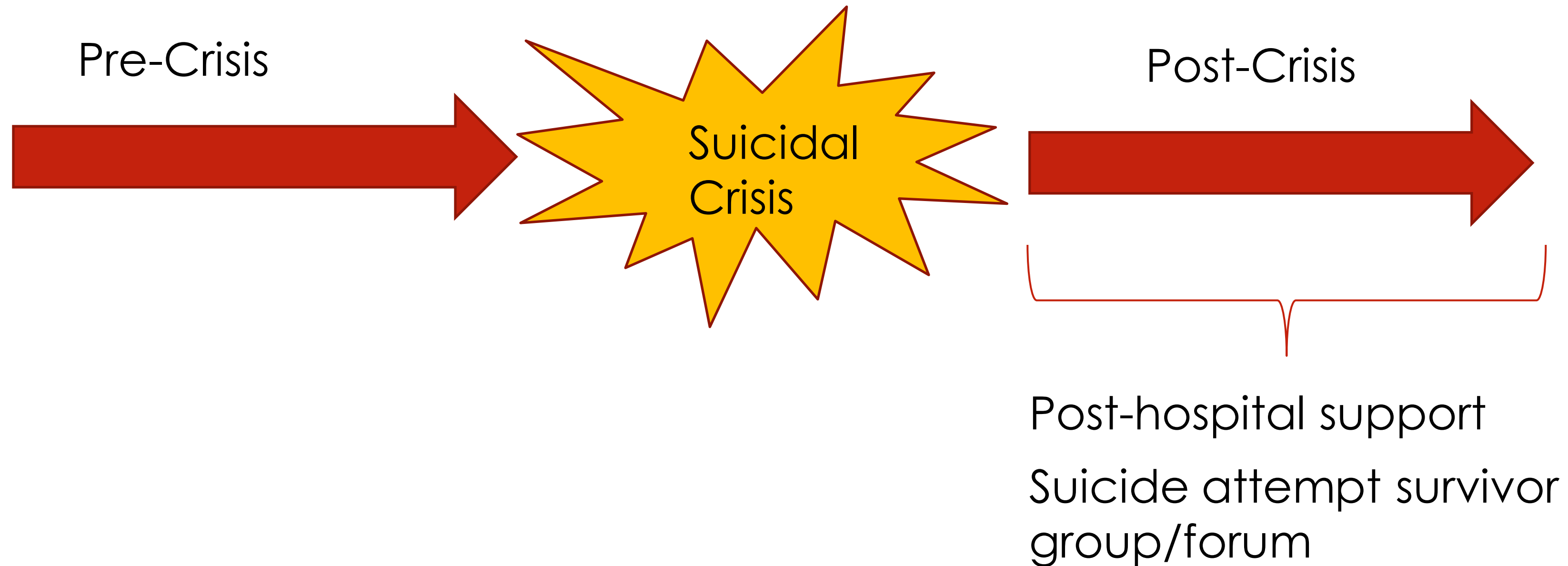
Crisis centers

Emergency departments

Inpatient psychiatric unit

Residential peer respite

ROLES OF PEERS IN SUICIDE PREVENTION



Post-hospital support

Suicide attempt survivor group/forum

Am J Community Psychol (2021) 68:232–248
DOI 10.1002/ajcp.12510

EMPIRICAL REVIEW

Peer-based interventions targeting suicide prevention: A scoping review

Nicholas W. Bowersox,[1,2] Jennifer Jagusch,[1,2] James Garlick,[1,2] Jason I. Chen,[3] and Paul N. Pfeiffer[1,2]

- 84 studies identified involving peers (broadly defined) and suicide prevention (excluded if only specified 'crisis')
- 3 randomized controlled trials
  - 1 study of employee gatekeeper training (Svensson; 2014)
    Improved skills and confidence
  - 1 pilot study of post-hospital peer specialist support (Pfeiffer; 2018)
    Established acceptability/feasibility
  - 1 trial of volunteer support for older adults (Van Orden; 2013)
    Not effective for reducing SI (Conwelll 2021)

Peer-based interventions targeting suicide prevention: A scoping review

- RTCs addressing crisis (but not suicide specifically)
  - 3 studies of post-crisis peer support (Johnson, 2018; Simpson, 2014; Sledge, 2011)
    Peer support recipients had fewer hospital readmissions in 2 of 3 studies
  - 1 trial of peer respite vs. inpatient psychiatry (Greenfield, 2008)

PEER-RUN RESIDENTIAL RESPITE

- Home-like environment
- Entirely peer-run and staffed
- House ~4-6 guests, only voluntary
- ~5 to 7-day stay
- Guests come and go freely

- Offer 1:1 peer support and group services such as WRAP, 12-step
- Can house warm line, community support groups
- May or may not require stable housing

http://www.hope365wellness.org/

PEER RESPITE EVIDENCE

- Greenfield et al. study, 2008
- 393 individuals presenting to a county crisis clinic randomized
- Compared to inpatient psychiatry, peer respite patients had:
  - Greater improvement in mental health symptoms (BPRS)
  - Greater satisfaction with care
  - Similar quality of life
  - Similar costs given greater readmissions (1.2 vs. 0.7 over 1 year) and greater total days
  - Suicide-related outcomes not reported

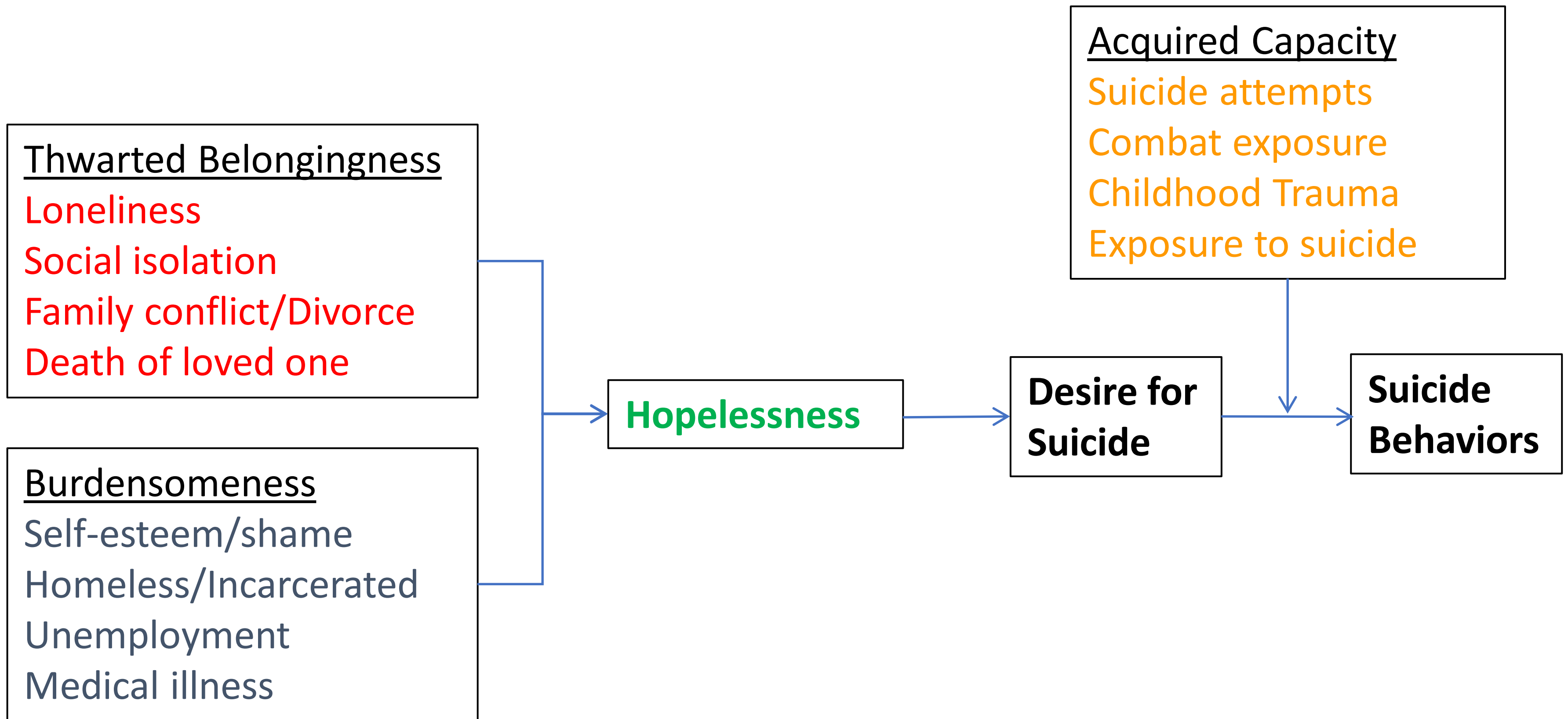
PEERS AND SUICIDE PREVENTION IN VA

- Peer support specialists embedded in facility SP teams
  - Caring letters
  - Means restriction counseling
  - Wrap Groups
  - Add'l contacts with HRF patients

- Peer support outreach center (PSOC)
  - Follow-up to Veterans Crisis Line callers
  - Identify and support wellness/recovery goals
  - Lethal means safety counseling
  - Utilize CSSR-S to triage suicide risk
- PREVAIL Pilot

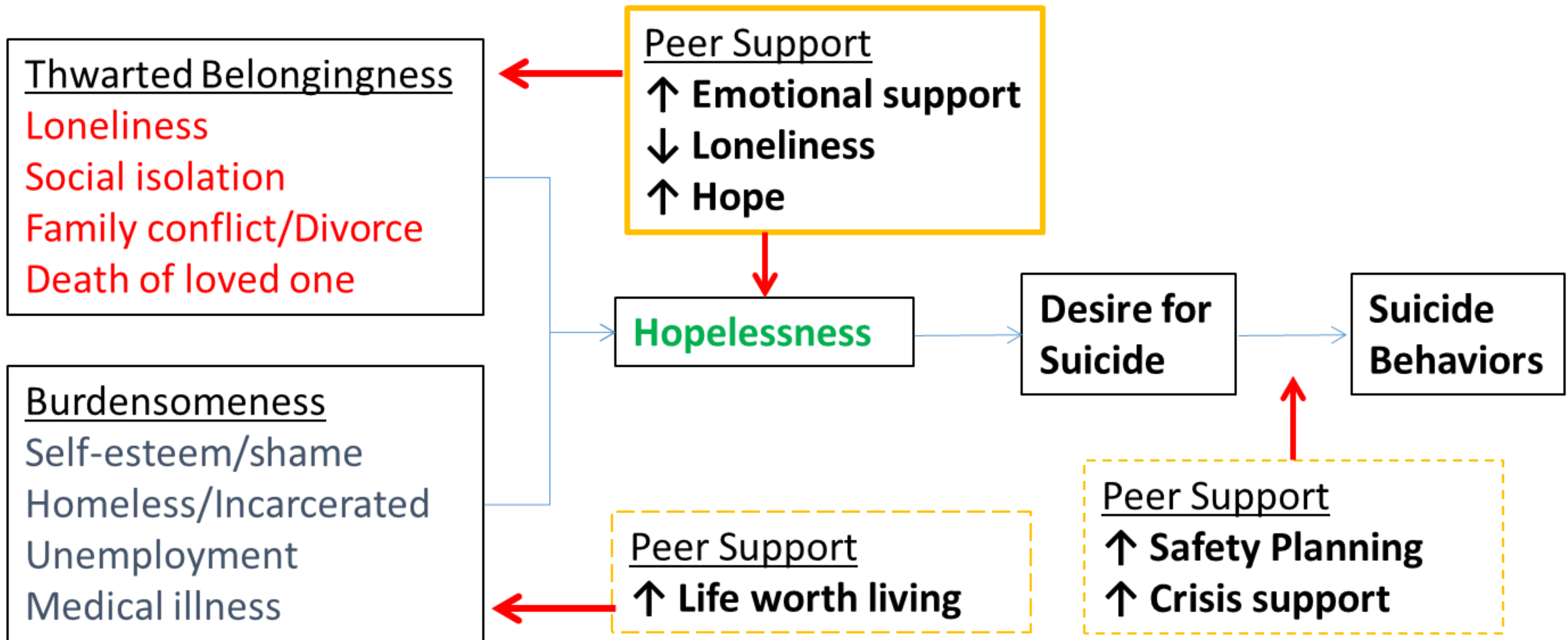
Peers for Valued Living: Peer Specialist Intervention for Suicide Prevention

Interpersonal Theory of Suicide



Adapted from Van Orden, 2010

How Peer Support May Reduce Risk



INTERVENTION PROTOCOL

1:1 Semi-structured Conversations over 12 weeks:

ILSM = Invite, Learn, Share, Motivate

- **Hope:** Physical reminders, e.g., hope kits; values, goals
- **Belongingness:** Strengthening social support network, grief and loss
- **Safety and distress:** Review safety plans, relaxation/mindfulness
- **Wellness and care:** Maintaining wellness, mental health care

Suicide risk assessed at each visit:

- "Have you been having thoughts of suicide" [yes/no]
- "Have the thoughts worsened since you last discussed with a clinician" [yes/no]
- "How likely is it you might act on your thoughts before you see your clinician again?" [not at all/somewhat/likely or very likely]

Supervision:

- On-call clinical back-up for crisis, 3-way call
- Weekly group meetings with clinician and other peer providers

RCT PROTOCOL

Sites: Two US inpatient psychiatry units

Participants:

Inclusion criteria: Suicidal ideation or attempt at admission

Exclusion criteria:

- Cognitive impairment, psychosis, or severe personality disorder that limits capacity to consent or ability to engage productively with peer
- Homicidal ideation or recent violent behavior

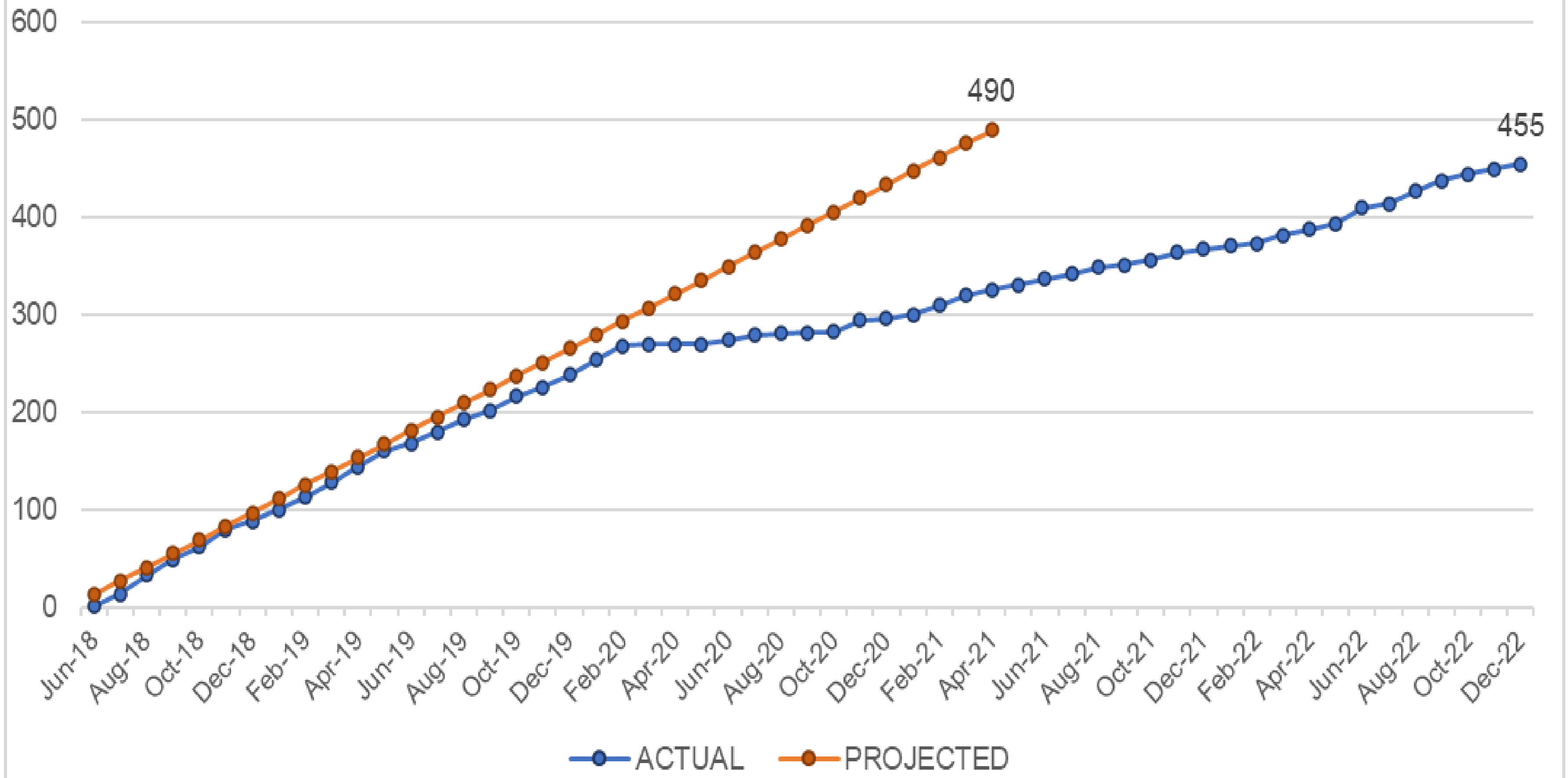
Procedure:

Randomized 1:1 to PREVAIL or usual care after completing baseline assessments

Primary outcomes:

- Suicidal ideation (Beck Suicide Scale)
- Suicide attempts (Columbia Suicide Severity Rating Scale)

Lapidos, 2019


PREVAIL Recruitment - Actual v. Projected
600
500
400
300
200
100
0
490
455
Jun-18
Aug-18
Oct-18
Dec-18
Feb-19
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
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Dec-21
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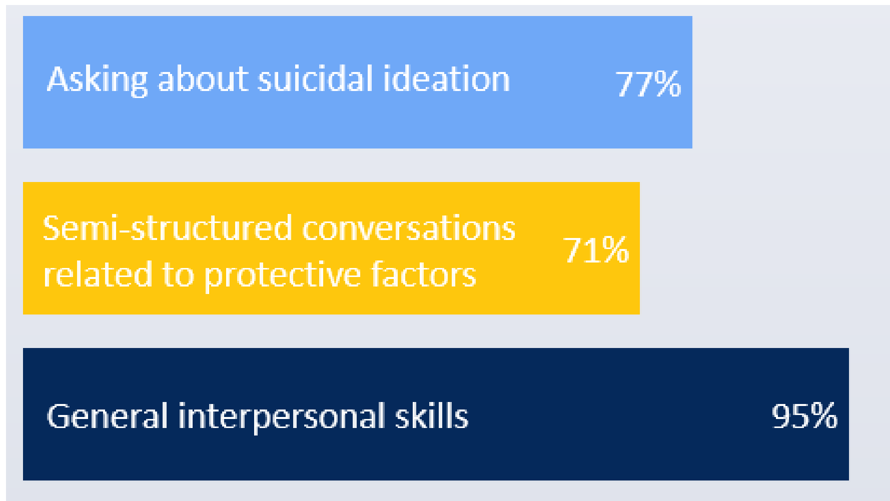
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
ACTUAL
PROJECTED

ACCEPTABILITY/FIDELITY

- Mean Peer Sessions Completed = 6.5
- Median Sessions = 6
- WAI-S Mean = 69.5 (item mean: 5.8 out of 7)
  - WAI-S range 12-84, higher score indicative of better relationship

Components adequately delivered



ILSM conversations delivered

Learning from the suicidal crisis, maintaining wellness	20%
Safety planning	20%
Goal-setting as means of improving hope	13%
Identifying values to help set goals	11%
Recognizing and managing distress	9%
Improving social supports	8%
Relaxation / Mindfulness / Self-soothing	7%
Coping with grief or loss	6%
Developing a hope kit or other reminders of reasons for hope	4%
Getting the most out of mental health care	2%

QUALITATIVE PARTICIPANT FEEDBACK

Participants semi-interviewed, n = 76
52 had a positive experience
9 had overall negative experience
9 had a mixed experience, and 6 were neutral

Theme 1: Emotional and instrumental support
Feeling understood helped them to express their feelings

Instrumental support included accompanying to a therapy session and support during suicidal crises

Theme 2: Sharing
Most helpful aspect – includes sharing about mental health and suicide and about themselves personally

Helped participants feel less alone and more hopeful

“She showed things from her perspective when she was going through the same thing I was... It just made me trust her more so I was able to share with her more of my feelings.... So it made me feel like there was a way out of the dark tunnel.”

“She had been there. She got it. And for once I didn’t feel so alone.”

QUALITATIVE PARTICIPANT FEEDBACK

Theme 3: Connecting outside of a clinical setting/context

Easier to be honest with them compared to a clinician

Appreciated connecting over shared hobbies, religion, and humor

Theme 4: Negative/mixed experiences

Age differences impacted relationship; saw older peer more as a role model/mentor, gave hope

Peer was too "clinical", did not share much

Peer's sharing was "trying too hard", peer's recovery story off-putting

"It was easy to be honest because it was someone who's experienced it before. It wasn't like reporting to my therapist or psychiatrist where I don't know if they've experienced that kind of thing or not. It was a little less pressure to be feeling good."

Re: sharing

"I felt like they were trying to - too angled, not bad intentions but trying to use it as a bridge too hard - yes common ground but not the same experience"

PREVAIL PEER FEEDBACK

Not formally studied, peer perspective paper in progress

- Overall enthusiasm for the experience
- Highly valued group supervision (peers and clinicians), crisis back-up
- Respect for the peer role and expertise
- Culture of learning
- Anticipate peers may need to step away

Out 14 peers hired for the study

- 5 left for other opportunities
- 5 left for personal health reasons, 2 to 4 of which appeared stress-related
- 3 left due to performance issues
- 1 was still working at end of study

VA PILOT OF PREVAIL

- Pittsburgh VA Medical Center
  - Matthew Chinman
  - Raymond Panas
  - Mala Shah
  - Jennifer McCoy
  - Lauren Krishnamurti
- Yale Program for Recovery and Community Health
  - Timothy Schmutte
  - Larry Davidson
- West Haven VA Medical Center
  - Anne Klee
  - Josh Bullock
  - Eugene Chesney
  - Raymond Russell
  - Alton Willis
  - Gregory Trotman
  - Theodore Jones
  - Maxine Barela
- VA Ann Arbor Medical Center
  - Paul Pfeiffer
  - Jennifer Jagusch

NEEDS ASSESSMENT

Qualitative interviews (N=9) with representative patients, providers, peers, SPC, service directors

- **Confirmed peer specialists have valued and unique role (relatability) in suicide prevention**

  "In a way it was easier to talk to them than anyone else. Cause, I don't know, they're real mellow about it and not pushing you, but more like asking you questions on what you wanted, what you want." -- Patient

  "They just come at it differently. You look at it differently. They talk to you differently. And sometimes it's really what you need… It's sure a lot safer, I don't know why." -- Patient

- **Concerns raised around:**
  - **Liability:** *"if a patient who's in crisis and the Peer Specialist is the only person that the patient speaks to and if there's a bad outcome, it could leave the hospital or the Peer Specialist open to risk." --Director*
  - **Psychological risk to peers:** *Carrying around and listening to some people's stories, not everybody can do that […] you kind of need to have the right stuff to be able to swim in some pretty despairing waters." --Peer Specialist*

- **Importance of group and individual supervision**

Schmutte, 2023

PRE-PILOT RECRUITED 9 VETERANS

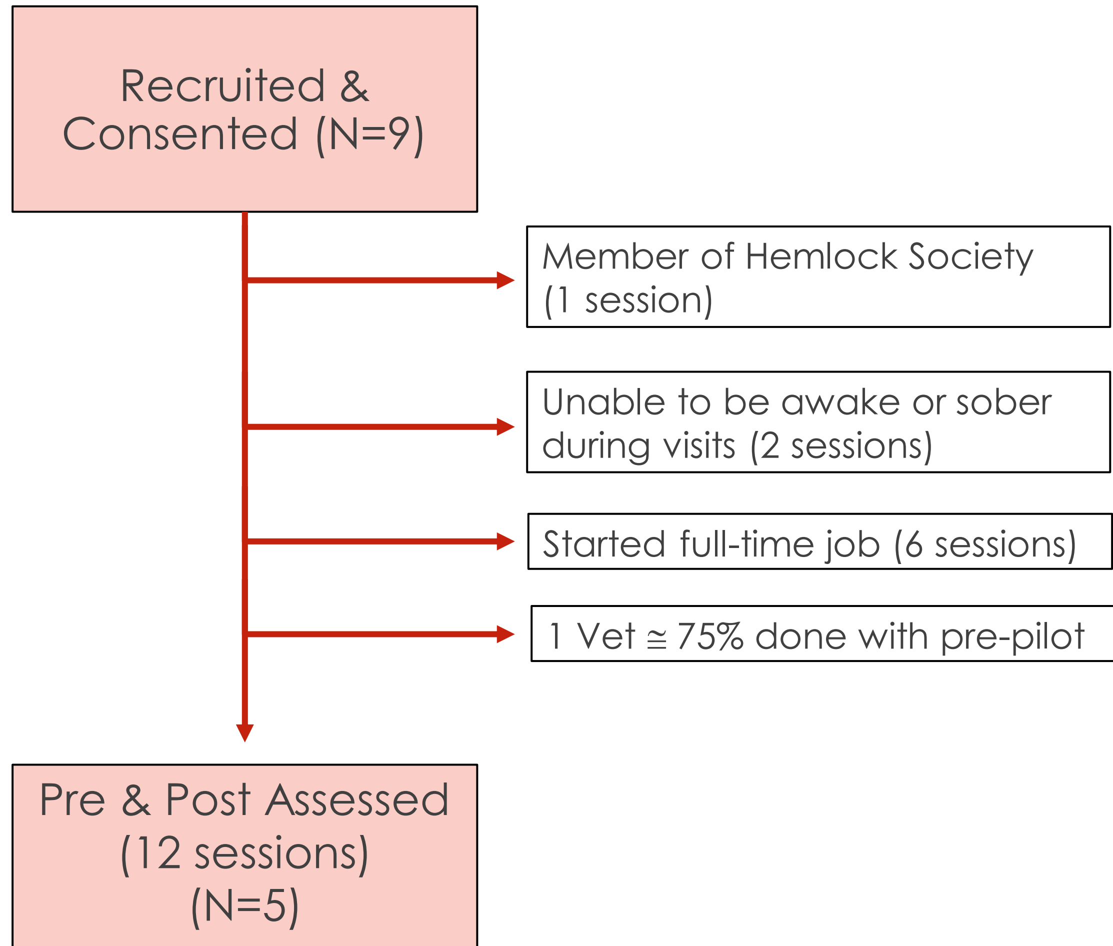
EVOLUTION OF RECRUITMENT

Clinician referrals and letters to Veterans on the high-risk list

- (≅ 1-2 out of 100)

Letters to Veterans with recent suicidal ideation or attempt, but not on high-risk list

- (≅ 8 out of 200)



ADDITIONAL VA PEER FEEDBACK

- **Initial anxiety:** *"It definitely wasn't as scary as I thought it was gonna be. Once I got through the first session I enjoyed it. I actually looked forward to meeting with my client each week."*

- **Difficulty with ILSM structure:** *"When I'm trying to follow that script with him, it was more uncomfortable. You know what I mean? It was uncomfortable for him. It was uncomfortable for me. But when we were just, like, ourselves and be natural. I think it was better."*

- **Valued emphasis on sharing**: *"I do like that we can incorporate lived experiences. I think that does help. Especially when the Veterans, you know, 'cause I've felt suicidal before too. So when you tell them they can, you get a kind of feel for them, and then they feel more comfortable around you to talk. So the lived experience is good. I like that"*

CONCLUSIONS

- Peers are highly acceptable and relatable to individuals at risk for suicide
  - Theoretically address suicide risk factors
  - Many potential roles
  - Lack of effectiveness trials

- Unclear risk/benefit to Peer Specialists providing intense 1:1 support to high-risk individuals (e.g., PREVAIL)
  - Many speak highly of the experience
  - Caution against double standards
  - Supervision and support are critical

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PREVAIL R01

Co-Investigators: Cheryl King, Mark Ilgen, Brian Ahmedani, Eduardo Vega, Kristen Abraham, Adrienne Lapidos, H. Myra Kim, Laura Damschroder, Jane Forman

Peer Specialists (PREVAIL R01): Becky Cronin, Teresa Nelson, Jason Sharp, Yarrow Halstead, Mert Hershberger, Deborah Monroe, Greg Monroe, Amy Siernecki, Regina Hendrix, Ryan Christman

Research Staff (PREVAIL R01): Jennifer Jagusch, James Garlick, Diana Curis, Sara Pasiak, Ellen Nixon, Caitlyn Heath, Kristen Hodge

DSMB: Lisa Brenner, Timothy Hofer, Richard Balon

VA PREVAIL Pilot

Pittsburgh VA Medical Center: Matthew Chinman, Raymond Panas, Mala Shah, Jennifer McCoy, Lauren Krishnamurti

Yale Program for Recovery and Community Health: Timothy Schmutte, Larry Davidson

West Haven VA Medical Center: Anne Klee, Josh Bullock, Multiple Peer Specialists

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