



The Role of Peer Support in Suicide Prevention

HSR&D Cyberseminar
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Disclosures

- No financial conflicts of interest

Outline of Talk

- Background & Theory
- Role of Peers in Crisis Support & Prevention
- Research study preview

Poll Question #1

What do you consider your primary role?:

- 1) Peer support
- 2) Clinical
- 3) Leadership / Management
- 4) Research / Evaluation
- 5) Other

Poll Question #2

How would you describe your background of expertise?

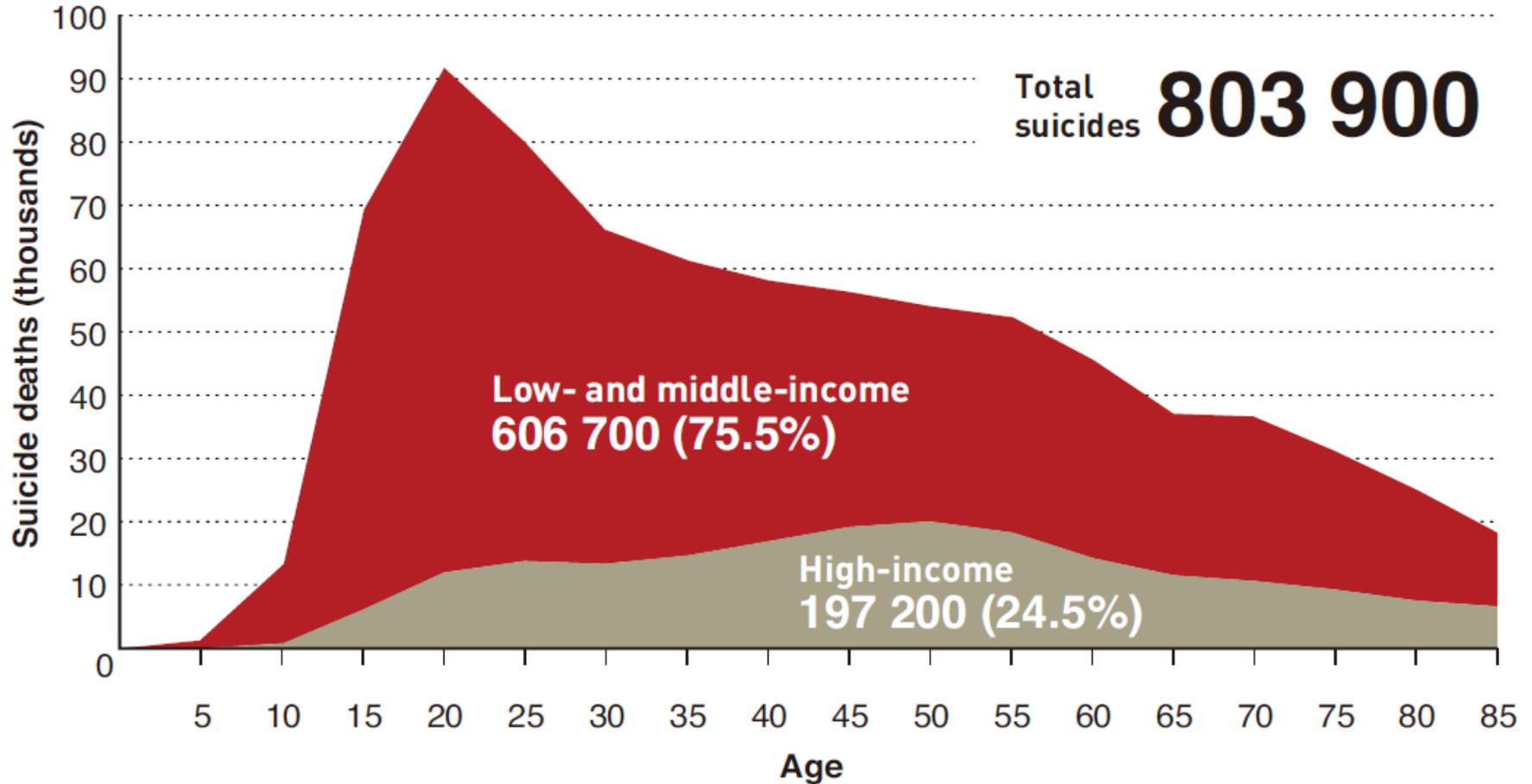
- 1) Peer support / recovery services
- 2) Suicide prevention
- 3) Both
- 4) Neither

The Bottom Line

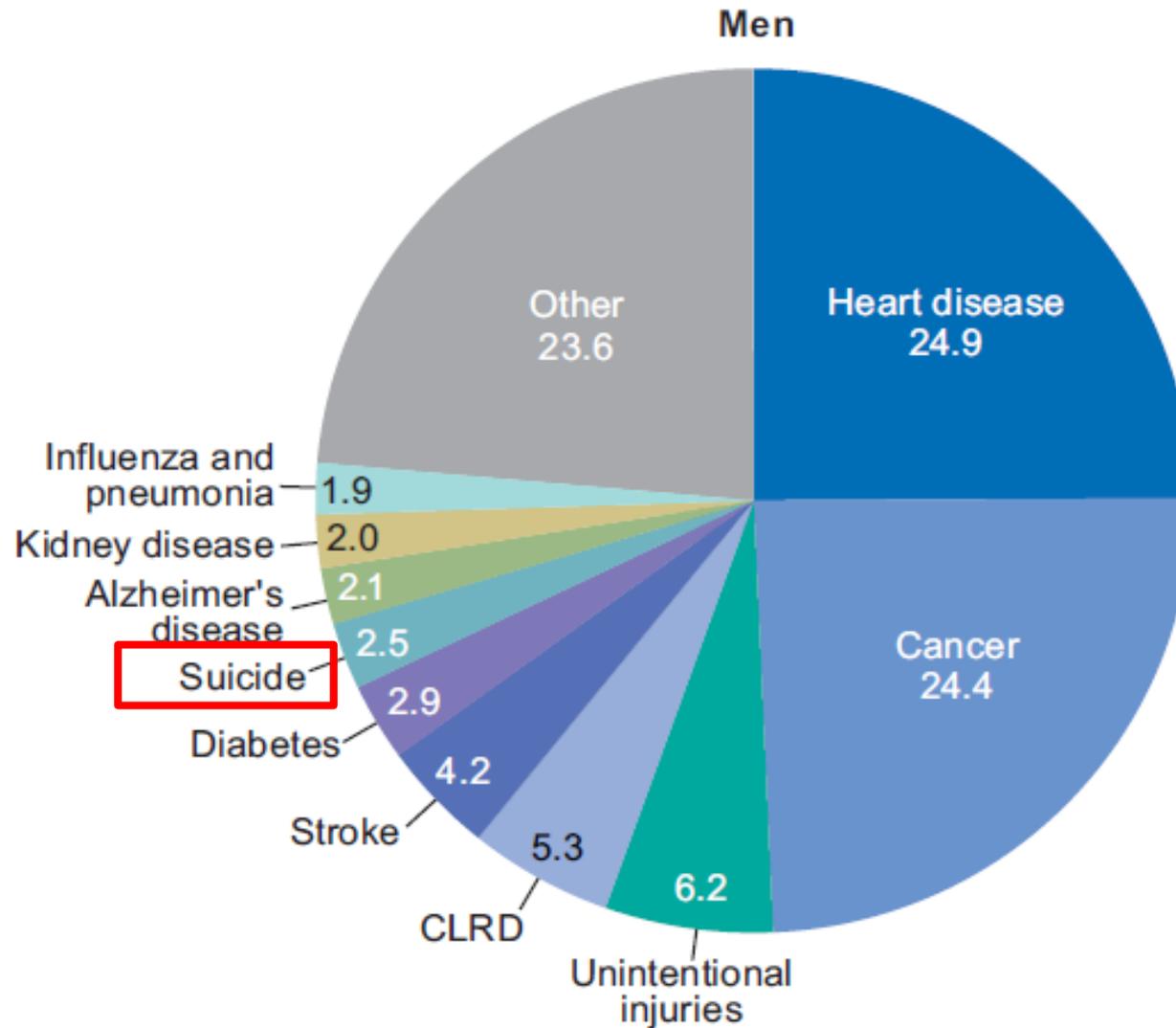
- There are good theoretical reasons to believe peer support can reduce the likelihood of suicide
- There is a national/international MOVEMENT to integrate peer specialists into the broad spectrum of crisis-related services
- There is some evidence that peer-run crisis services have high consumer satisfaction and can be cost-saving alternatives to psychiatric hospitalization
- There is no research evidence that peer support services improve suicide-specific outcomes such as suicidal ideation, attempts, or suicide death

Background & Theory

Global Suicide Deaths in 2012

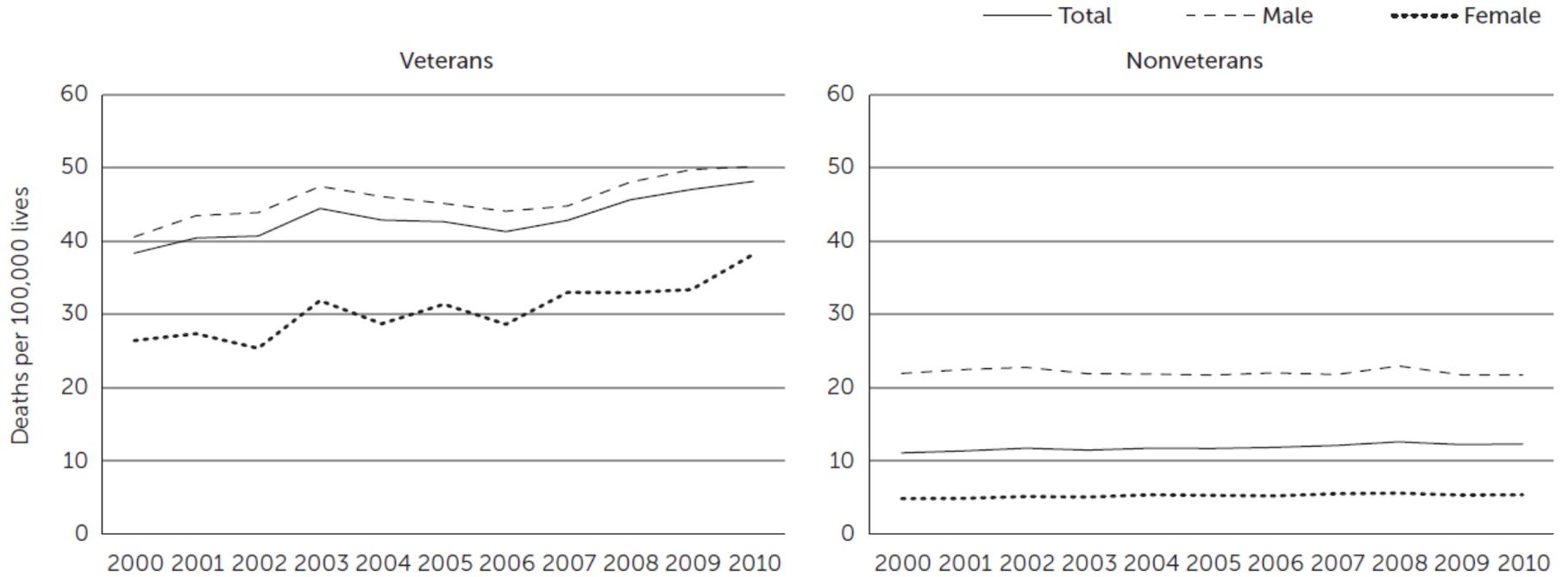


Leading Causes of US Mortality, 2010



NOTES: CLRD is Chronic lower respiratory diseases. Values show percentage of total deaths.
SOURCE: CDC/NCHS, National Vital Statistics System, Mortality.

Trends in Veteran and Non-Veteran Suicide Rates



Source: Hoffmire, 2015

New Approaches to Suicide Prevention Needed

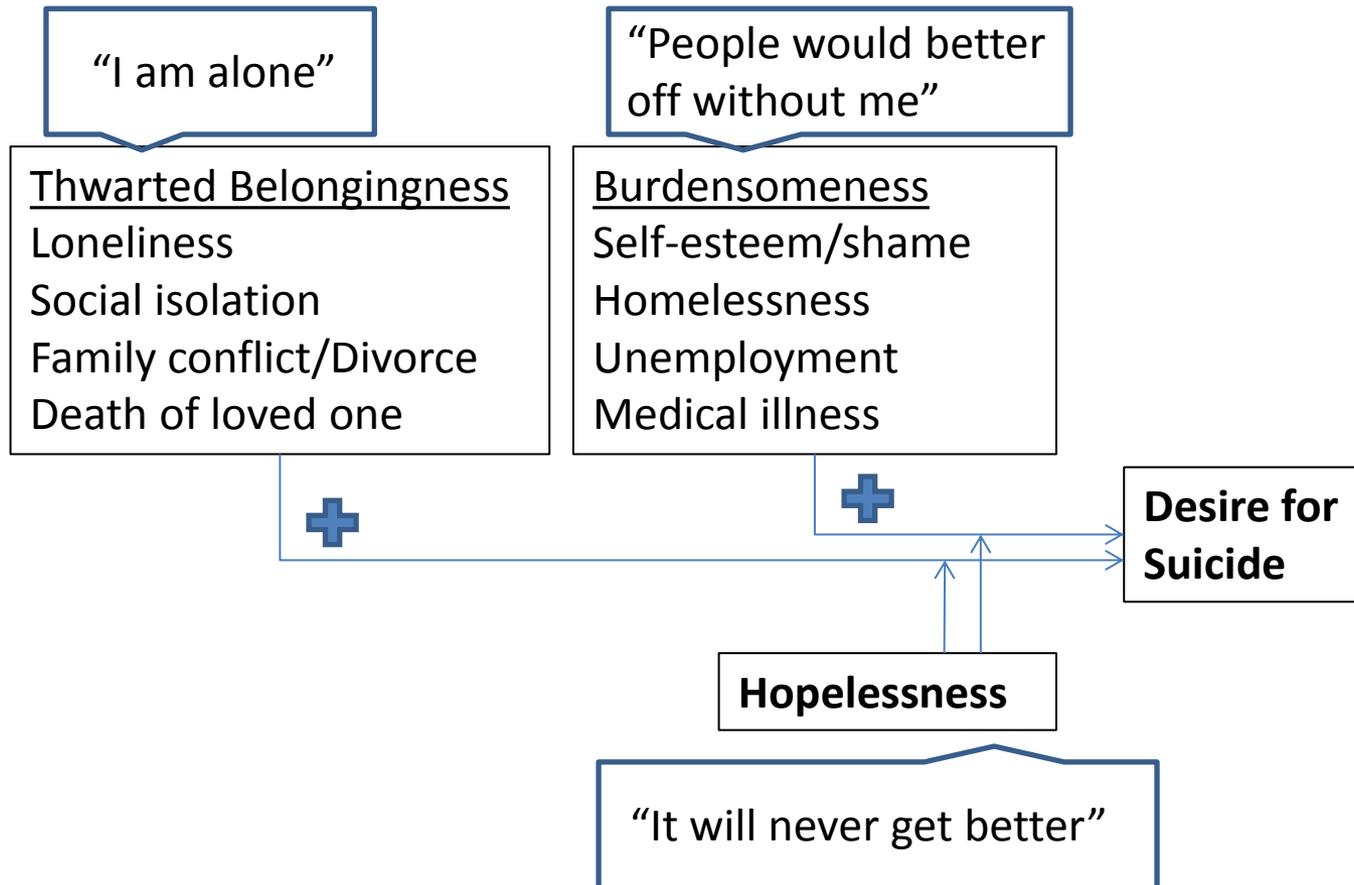
Ideally should:

- Address known risk factors
- Have limited barriers to implementation
 - Acceptable and accessible to recipients
 - Affordable and scaleable

Risk Factors for Suicide

- Mental health disorders
- Prior suicide attempts
- Social isolation
- Physical illness
- Unemployment
- Family conflict
- Family history of suicide
- Impulsivity
- Incarceration
- Hopelessness
- Seasonal variation
- Serotonin dysfunction
- Agitation, insomnia
- Childhood trauma
- Exposure to suicide
- Homelessness
- Combat exposure
- Low self-esteem, shame

Interpersonal Theory of Suicide



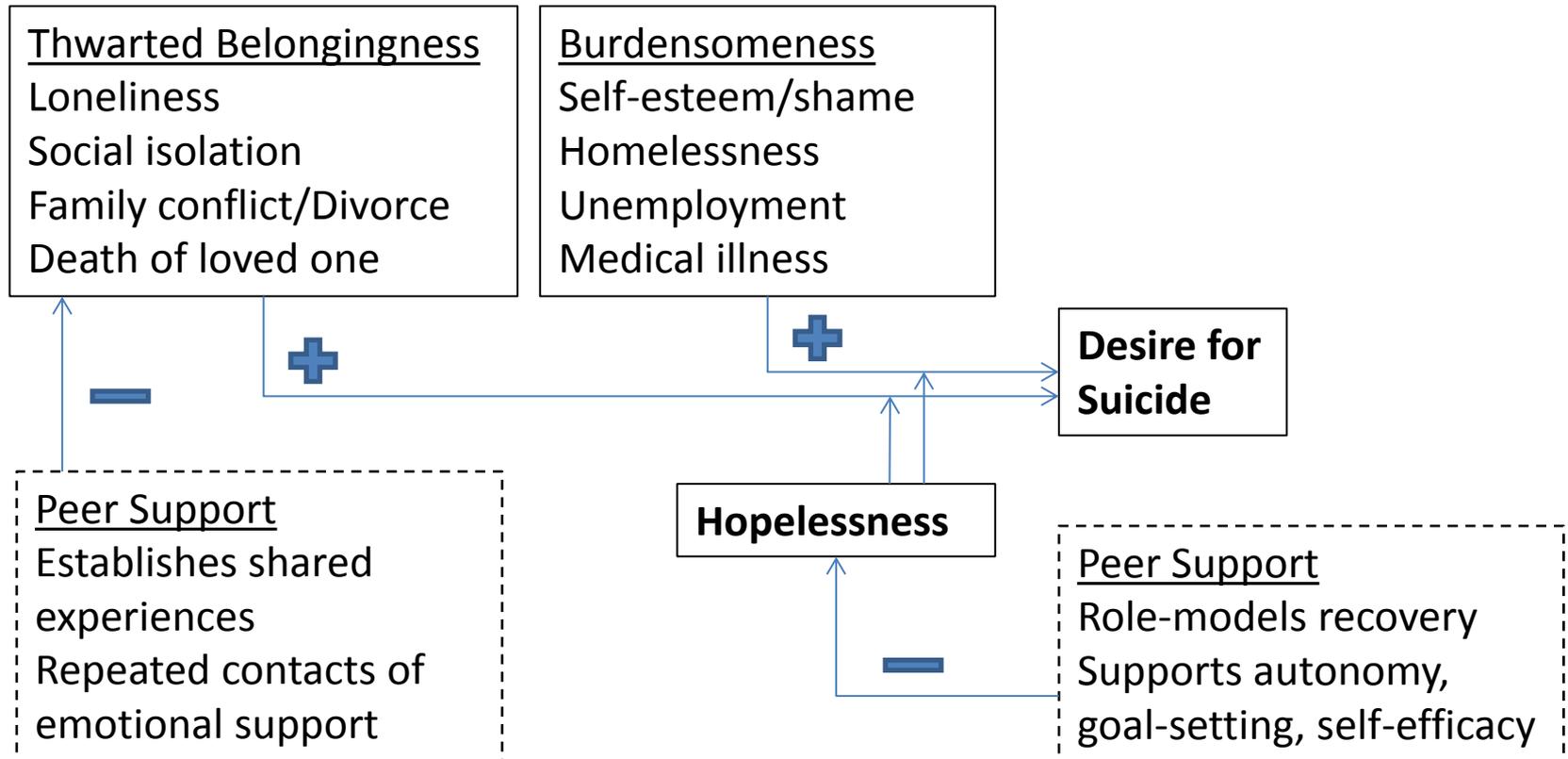
Suicidal Ideation Among Depressed VHA Patients

	No SI	Passive SI	Active SI
Control variables	(N=249)	(N=116)	(N=78)
Age 18–44, %	22.4	13.2	18.0
Age 45–64, %	62.7	68.4	66.7
Age 65+, %	14.9	18.4	15.4
Male sex, %	72.7	85.0 ^a	94.7 ^{a,b}
White, %	74.6	72.6	75.6
Black, %	16.0	17.2	16.7
Other race, %	9.4	11.2	7.7
Somatic-affective depression, Mean (SD)	15.5 (6.6)	18.1 (6.8) ^a	21.7 (6.0) ^{a,b}
Primary independent variables			
Hopelessness, Mean (SD)	7.1 (5.0)	10.4 (5.8) ^a	12.5 (5.4) ^{a,b}
Burdensomeness, Mean (SD)	5.6 (3.6)	7.7 (3.6) ^a	9.0 (3.5) ^{a,b}
Belongingness, Mean (SD)	68.4 (21.9)	64.2 (20.6)	53.6 (20.3) ^{a,b}

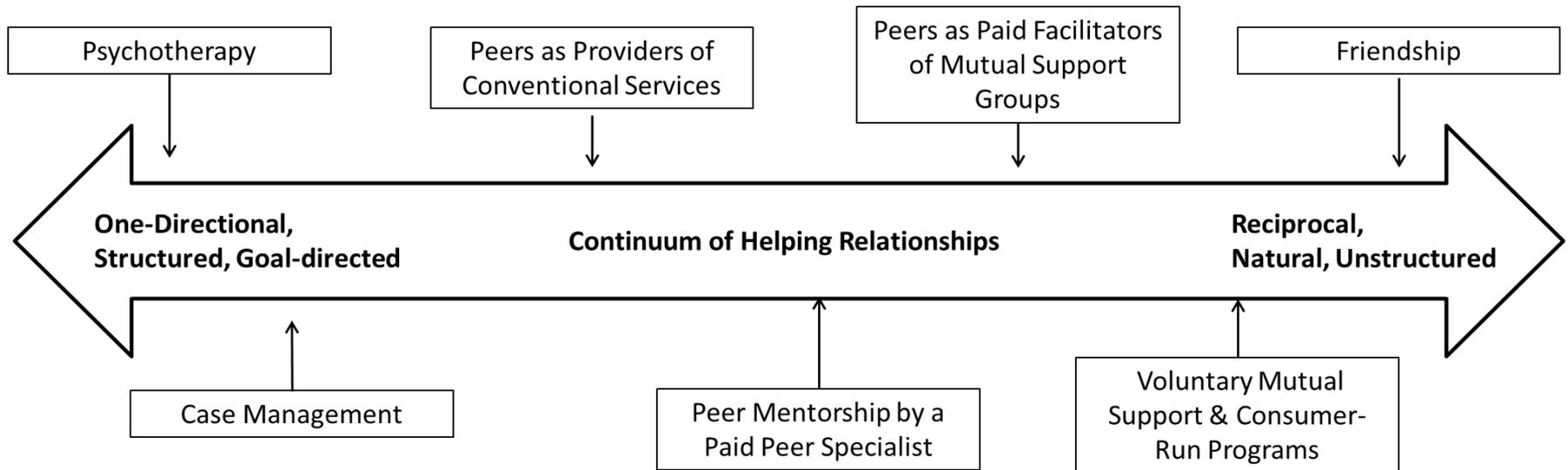
^a $p < 0.05$ compared to No SI.

^b $p < 0.05$ compared to Passive SI.

Interpersonal Theory of Suicide & Peer Support



What is Peer Support?



Certified Peer Support Specialists (CPSS) are individuals with a lived experience of mental health challenges who have received training and certification and are paid to provide support to others with mental health challenges.

The VA has complied with an executive order by Obama to hire 800 CPSSs across the system.

Most VAMCs have at least 3 Certified Peer Support Specialists on staff.

Adapted from Davidson, 2006

What does the evidence say about the effect of “general” peer support services on suicide risk factors?

(General = meaning not crisis/suicide specific)

Do Leading Peer Services Reduce Suicide Risk Factors?

RCT Results of Wellness Recovery Action Planning (WRAP) vs. Wait List control

Measure by Time Point	Intervention		Control	
	Mean (SD)	No.	Mean (SD)	No.
BSI global severity index				
Baseline	0.76 (0.72)	251	0.73 (0.73)	268
Postintervention 1	0.72 (0.64)	224	0.85 (0.70)	234
Postintervention 2	0.42 (0.61)	220	0.47 (0.67)	228
Hope				
Baseline	21.67 (4.66)	248	21.87 (4.42)	264
Postintervention 1	22.47 (4.39)	221	22.07 (4.06)	228
Postintervention 2	22.76 (4.68)	212	22.16 (4.21)	222

Do Leading Peer Services Reduce Suicide Risk Factors?

RCT Results of Vet-to-Vet VA Peer Support Group

- No overall effect on social support, hope, or mental health symptoms compared to usual care.
- “Dose effect” among group participants for improvement in symptoms but not for social support or hope

Do Leading Peer Services Reduce Suicide Risk Factors?

RCT of Adding Peer Support Specialist to VA MHICM Team

- No overall effect on symptoms, quality of life, or measures of recovery other than an improvement in activation.

Do Peer Services Reduce Suicide Risk Factors?

Peer Support for Depression

- Meta-analysis of 7 RCTs (849 participants) demonstrated positive effect for a mixed array of Peer Support interventions for depression vs. Usual Care with effect size of 0.59 (95% CI, -0.98 to -0.21; P=.002)
- RCT of mutual dyadic peer support for depressed VHA patients was not associated with improvement in depression, hopelessness, or suicidal ideation.

Evidence Summary

- There is limited evidence that “general” peer support services reduce suicide risk factors.
- What about Crisis-specific Services?
 - **Bottom Line: They haven’t been studied**
 - Mainly pilot studies/demonstration projects

Roles of Peers in Crisis Services

- “Warm” lines
- Mobile crisis / Crisis resolution teams
- Drop-in alternative to ED
- Residential alternative to Hospitalization
- Members of ED/Inpatient teams
- Training first responders
- Post-crisis support

What is driving the movement?

- Existing crisis services are seen by many individuals as traumatic, humiliating, and disempowering
 - Involuntary commitment
 - Police involvement
 - Restraints
 - Forced medication
 - Removal of clothing / belongings
 - Sterile / cold surroundings
 - Isolation from friends & family
 - Excessive wait / “boarding” times
 - Discourteous staff

Warm Lines



- Peer-run call-in centers
- Often operate “after hours” when other clinical/peer services are not available
- Serve as a “pre-crisis” alternative to crisis hotlines
- Peers offer emotional support, hope, and the benefit of their experience
- Peers are trained in communication skills and when to transfer to a crisis line

Warm Line Evaluation

- Survey of 400+ callers to a peer-run state-wide warm line (WL)
- 89.6% satisfaction with service
- Reductions in ED and crisis call use after implementation
- Majority reported WL helped with coping skills, sense of well-being, empowerment, and personal recovery
- Complaints included:
 - Not personally connecting with peer specialist
 - Wait times to reach someone and then feeling rushed to end call

Mobile Crisis Teams



- “Go to where the patient is”, including home or in the community, to provide support and linkage to resources
- Activated by call to crisis line, law enforcement (following outreach), clinicians, etc.
- Often seen as a having more of a “pre-crisis” role, referring to clinicians for immediate safety issues
- Training: peer support 101, trauma-informed care, WRAP, crisis intervention training, suicide prevention, compassion fatigue
- Support: clinical supervision and wellness coaching

Mobile Crisis Team Evaluation

- 1 year pilot study conducted in 2 counties in Montana
- 2 embedded peer support specialists
- 90 referrals, 749 contacts
- Estimated \$132,960 saved in diversion from ED or hospital stays (~\$200,000 over 1 year)
- Program cost \$118,216

Source: Jim Hajny, Executive Director

ED Alternatives

- The Living Room
 - Crisis center operated in Skokie, Illinois
 - Staffed by 3 peer counselors, 1 nurse, and 1 therapist
 - Arranged like an actual living room, “home like” environment
 - Attached to CMH clinic with separate entrance
- Qualitative findings from interview of staff & guests
 - “Safe harbor”
 - “At home with uncomfortable feelings”
 - “Helping, no judgment zone”
 - Some concern about people using the Living Room for support when not in crisis





Member of ED Team

- 2011 descriptive study by Migdole et al.
- Employed peer specialists to provide MH crisis support in ED
- 2 peer specialists on duty at time
 - Orient patients to ED/procedures, liaison with patient advocates, provide general support, provide comfort items and companionship (play cards)
- Preliminary/anecdotal evaluation suggested improved patient satisfaction
- Challenges related to:
 - Chaos/stress ED triggering for peers
 - Navigating when peers become ED patients

Residential Crisis Services / Respite / Hospital Diversion

- “Rose House” model by PEOPLE, Inc.
 - Based in New York, lead by Steve Miccio
 - Staffed and operated 24/7 by Peer Specialists
 - Houses up to ~4 guests, voluntary basis
 - 1 to 5-day stay, stable housing required
 - Offers 1:1 peer support and group services, such as WRAP, 12-step
 - Also houses warm line and offers mobile crisis services

Rose House alternative to psychiatric hospitalization



Rose House – Evaluation 2014

- 128 unique guests for 506 residence days
- 3,400 warm line calls, 207 mobile visits
- Operating cost: \$249,000
- Cost if admitted to local hospital: \$809,600
- 11% admitted to inpatient w/in 30 days of leaving Rose House
- 97% reported feeling better and more socially connected

Residential Crisis Services Trial

RCT of Consumer-managed Residential Program (CRP) + ACT vs. Locked Inpatient Psychiatric Facility (LIPF)

- CRP patients had greater improvement in psychopathology and much greater satisfaction with care
- CRP has slightly longer stays (7.1 vs. 5.8 days) and had more readmissions (1.2 vs. 0.7)
- Quality of life and costs were similar*

Poll Question

- Should the VA support Peer-run residential respite facilities as an alternative to the ED and psychiatric hospitalization?

1: Yes

2: No

3: Only if further study has shown it to be safe and effective

4: Not sure / No opinion

Post-crisis Support

- 1:1 and/or group peer support services following psychiatric hospitalization
- Mixed RCT evidence
 - Sledge et al. RCT found peer support reduced subsequent readmissions (0.9 vs. 1.4) and hospital days (10.1 vs 17.3) compared to usual care
 - Simpson et al. RCT found peer support has no effect on recovery outcomes or costs though trend for improvement hopelessness

VA Pilot Study of Post-hospital Support

- Enrolled patients admitted with depression diagnosis
- 29 participants chose a peer specialist while 19 chose a family member or friend for post-hospital support
- 18.8% readmitted in 3 months. Moderate MH service use, 6.7 visits in 3 months, 11.8 in 6 months
- Depression* and anxiety symptoms improved
- No change from baseline to 3 or 6 months in:
 - Suicidal ideation
 - Hopelessness
 - Perceived social support
 - Activation
 - Functioning

Training Options

- Applied Suicide Intervention Skills Training (ASIST)
 - Over 1,000,000 trained
 - Study of National Suicide Prevention Lifeline workers demonstrated improved caller outcomes w/ ASIST training
 - Callers less suicidal, overwhelmed, and depressed, more hopeful
- Emotional CPR (eCPR)
 - Recovery-informed approach to crisis support
- Mental Health First Aid
 - Intended for general public
 - Increases knowledge, confidence, and attitudes regarding mental health

Summary

- Evidence suggests peer-run crisis services have high consumer satisfaction and can be cost-saving alternatives to psychiatric hospitalization
- The effect of peer support services on suicide-specific outcomes such suicidal ideation, attempts, or suicide death is non-existent
- Research on suicide-specific outcomes is needed

PREVAIL Study

- PREVAIL is a NIMH-funded pilot study of 12 weeks of 1:1 Peer Mentorship to Reduce the Risk of Suicide after a Psychiatric Hospitalization
- PREVAIL training was developed with expert panel input from:
 - Peer support and suicide researchers
 - Peer specialists
 - State peer specialist training coordinator
 - The Center for Dignity, Recovery, and Empowerment
- The 3-day training was taught to selected Michigan Certified Peer Support Specialists with > 1 year of peer support experience

The logo for PREVAIL Training features the word "PREVAIL" in a bold, blue, sans-serif font. The letters "V" and "A" are stylized, with the "V" having a blue circle above it and the "A" having a blue circle above it. To the right of "PREVAIL" is the word "Training" in a black, sans-serif font.

PREVAIL Training

- Balance between supporting autonomy and recovery while also enabling peers to use specific tools/skills to help patients improve their sense of hope and belongingness
- Main components
 - Communication skills: listening, validation
 - Sharing one's story regarding suicidal crisis
 - Addressing suicidal crises & when to get help
 - Skills for improving hope
 - Skills for improving belongingness
 - Skills for improving engagement



PREVAIL Study Details

- 60 patients from the University of Michigan Inpatient unit will be randomized to either PREVAIL or usual care
- Primary outcomes will be suicide attempts and suicidal ideation at 3 months and 6 months
- Secondary outcomes will include levels of hope and perceived social support
- CPSS will receive weekly supervision
- All meetings will be recorded to determine fidelity to the training model

PREVAIL Study Details

- Recruitment scheduled to start this month
- Stay tuned!
- Plan to extend to VA sites during or after pilot

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Resources

Webinar on Peers as Crisis Service Providers

<http://www.nasmhpd.org/content/peers-crisis-service-providers>

Mobile crisis team contact info

Jim Hajny, Executive Director: jim@mtpeernetwork.org

Manual of peer-run residential hospital diversion

<https://www.power2u.org/downloads/OH-Hospital-Diversion-Manual.pdf>

ASIST training site:

<https://www.livingworks.net/programs/asist/>

Questions/Comments?

Contact Information

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