

Lived Experience Leadership and Peer Support Services

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Disclosures

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About SPRC

The Suicide Prevention Resource Center (SPRC) is the only federally funded resource center devoted to advancing the implementation of the National Strategy for Suicide Prevention. SPRC is supported through a grant from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA).

SPRC builds capacity and infrastructure for effective suicide prevention through consultation, training, and resources for state, tribal, health/behavioral health, and community systems; professionals and professional education programs; and national public and private partners and stakeholders.



CME Credit

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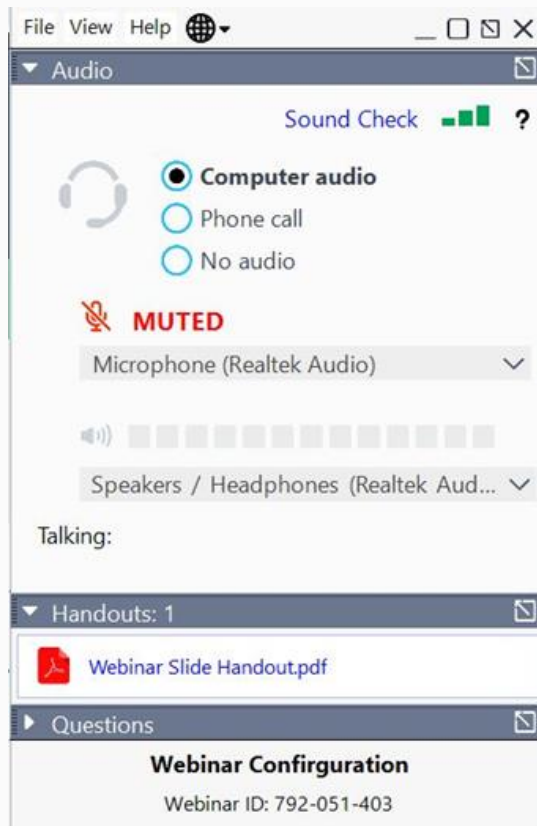
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How To Download Handouts

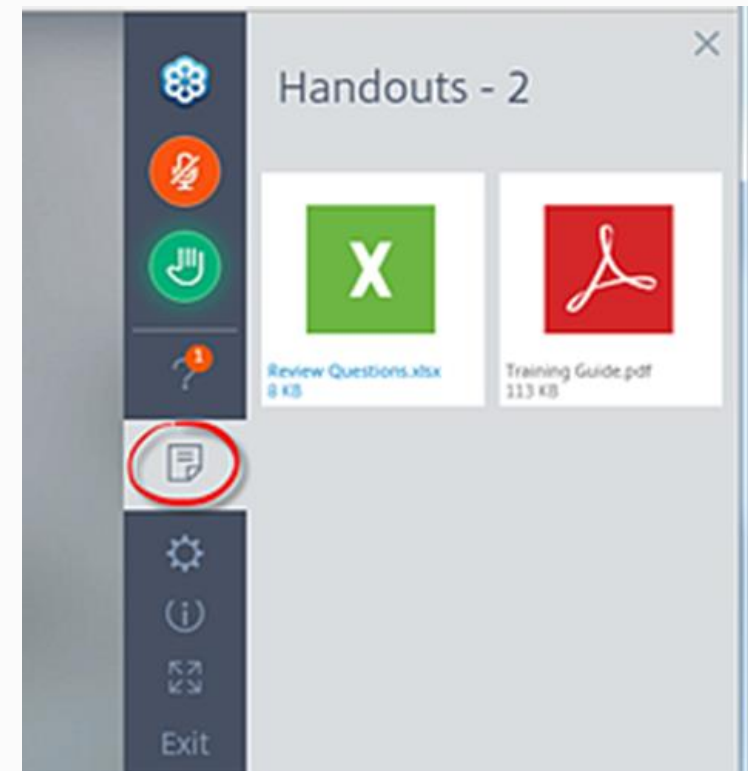
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Use the “Handouts” area of the attendee control panel.



Instant Join Viewer

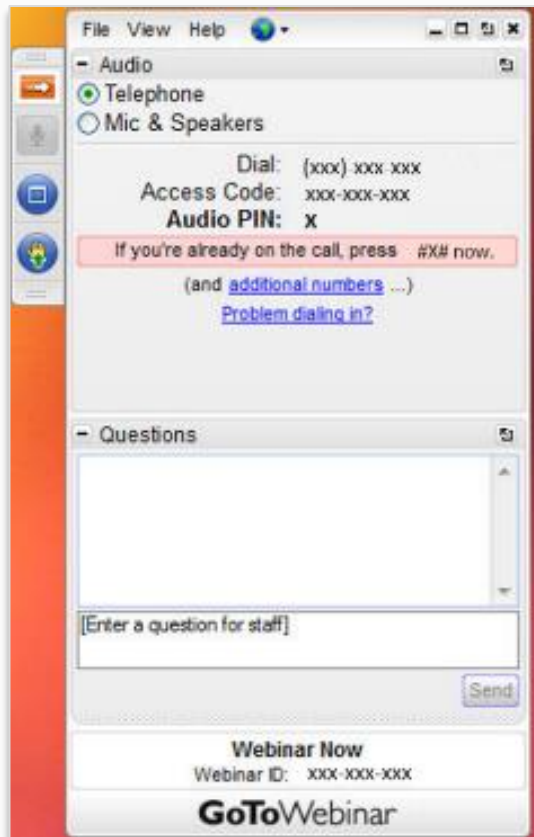
Click the “Page” symbol to display the “Handouts” area.



How To Participate in Q&A

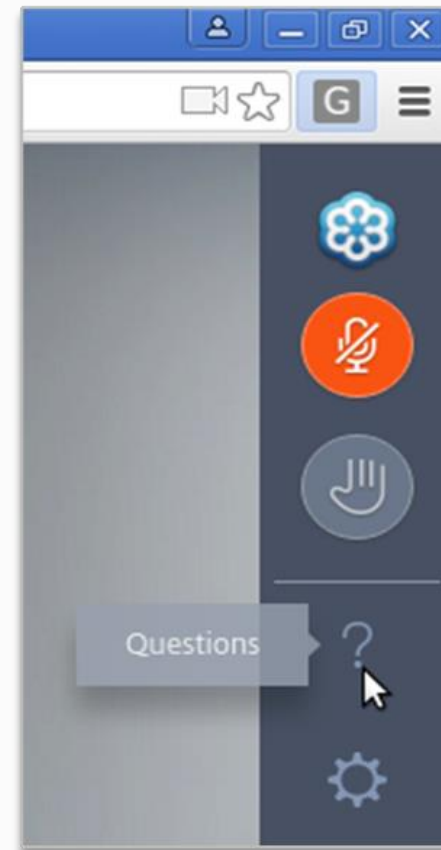
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Use the “Questions” area of the attendee control panel.



Instant Join Viewer

Click the “?” symbol to display the “Questions” area.



Moderator



Julie Goldstein Grumet, PhD

Zero Suicide in Health Care Systems



Zero Suicide is useful for any system interested in providing the most effective and data-informed suicide care practices available.

Systems that adopt the Zero Suicide mission are:

- » Challenging themselves to be high-reliability organizations.
- » Embedding evidence-based interventions into care practice.
- » Collecting data to measure both outcomes and fidelity.
- » Improving continuously through training and protocols.
- » Normalizing suicide prevention for clients, staff, and families.



Zero Suicide Framework

CORE COMPONENTS OF SAFE SUICIDE CARE

- » These seven elements are critical to safe care.
- » Represent a holistic approach to suicide prevention.
- » Can and should be considered on a simultaneous continuum.



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Zero Suicide Toolkit

Your practical guide to systemic change.

The online Zero Suicide Toolkit offers free and publicly available tools, strategies, and resources.



RESOURCES

- » Information
- » Materials
- » Outcomes
- » Innovations
- » Research
- » Tools
- » Readings
- » Videos
- » Webinars
- » Podcasts

The screenshot shows the Zero Suicide Toolkit website homepage. At the top, there is a navigation bar with the Zero Suicide logo and links for 'OUR TEAM', 'WHAT'S NEW', 'CONTACT US', 'LOG IN', and 'ZERO SUICIDE INSTITUTE'. Below the navigation bar is a search bar and a menu with links for 'Home', 'About', 'Evidence', 'Movement', 'Toolkit', and 'Resources'. The main content area features a large yellow banner with the headline 'Study: Zero Suicide Practices Reduce Suicides'. Below the headline is a sub-headline: 'New study shows patients at outpatient clinics using Zero Suicide practices significantly less likely to attempt suicide.' A 'Learn More' button is positioned below the sub-headline. To the right of the text is a large, faint circular arrow graphic. Below the banner is a section titled 'SAFER CARE FOR THOSE AT RISK OF SUICIDE' with the sub-headline 'Zero Suicide is a Transformational Framework for Health and Behavioral Health Care Systems'. To the right of this text is an image of two healthcare professionals, one in a white lab coat and one in blue scrubs, with their hands clasped together. Below the image is a paragraph of text explaining the foundational belief of Zero Suicide. At the bottom of the page is a dark grey footer containing logos for the National Action Alliance for Suicide Prevention, UHS, ZEROsuicide INSTITUTE, SPRC, and SAMHSA. A large yellow banner at the very bottom of the page displays the website URL 'zerosuicide.edc.org'.

Lived Experience

Involving People with Lived Experience

Until recently, the field of suicide prevention has rarely tapped the first-person knowledge of suicidal behavior and reattempt survivors bring to the table. The field, along with health and behavioral health care organizations, is now beginning to receive the most intimate information about suicidal thoughts, feelings, and actions—those who have lived through such experiences.

The Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention recently issued the report *Hope, Recovery, and Wellness with Insights from Lived Experience*. The report offers a set of core values to inform suicide-specific recommendations for health and behavioral healthcare organizations and program developers.

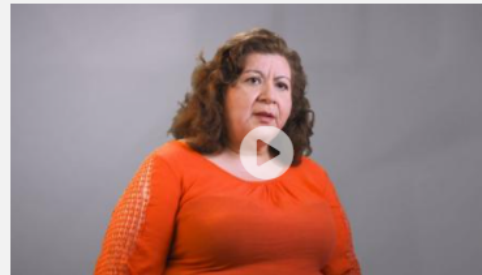
For the organization developing a Zero Suicide approach, one of the first actions should be to partner with people with lived experience in implementing, and evaluating efforts. For example, a Zero Suicide Implementation Team should include at least one

LIVED EXPERIENCE | VIDEOS



Lived Experience: Aftercare That Makes a Difference

Lived experience expert Diana Cortez-Yanez discusses transitions through care and the supportive contacts that helped her recover.



Lived Experience: Aftercare That Makes a Difference

Diana Cortez Yanez

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A lived experience expert discusses transitions through care.

Tags: [Support Services](#) [Contact after Leaving Care](#) [Inpatient Mental Health](#) [Lived Experience](#) [Web](#) [Treat](#) [Transition](#)

Learning Objectives

- Design strategies to foster an organizational culture that prioritizes lived experience as a central component of systems change focused on suicide prevention.
- Identify staff training considerations and practices that facilitate peer support service delivery and leadership within an organization.
- Describe how individuals with lived experience can help aid warm handoff practices to ensure safe care transitions between services and levels of care.

Presenter



Lisa St. George, MSW, CPRP, CPPRSS



THE EXPERTISE, ABILITIES, AND ETHICS OF PEER SUPPORT

Lisa St. George, MSW, CPRP, CPPRSS

Vice President of Peer Support and Empowerment

RI International

Recovery Is a Fact!

I had been taught to manage serious mental illnesses with a set of assumptions that if articulated would sound something like this: “People with chronic mental illness are permanently disabled. Medicate them and forget them. They are weak and need to be taken care of. They can’t hold down jobs. They have no significant role to play in society. The possibility of them having a meaningful life is slight. Their prognosis is essentially hopeless.”

– Mark Ragins, MD

In 1991 Dr. Ragins met Bill Anthony, who said that the “next big movement in mental health” would be “recovery.” Dr. Ragins nearly fell out of his chair. The idea of recovery “seemed too extreme to ever become acceptable.”

Source: Ragins, M. Road to Recovery. [Road-to-Recovery.pdf \(bu.edu\)](#)

Lived Experience Leadership and Peer Support Services



How wonderful to
work in a field
where today we
have so much
hope for recovery!



Lived Experience as Expertise...

- » Lived experience is not new.
- » Historically, people learned a trade through practice.
- » Lived expertise includes skills and deep knowledge from life experiences.
- » People who have received mental health and/or substance use services learned to traverse complicated systems to get their needs met.

Lived Experience as Expertise (continued)

- » Training and credentialing
- » Practice guidelines established by the National Association of Peer Specialists
- » Core Competencies developed by SAMHSA
- » Peer Support Ethical Values
- » RI International ethical guidelines for peer support workers



Many Systems and Organizations

- » Exist with only one or two peer supporters
 - » Serving a few people
 - » Greeting people as they enter
- » Filing, phone, providing transportation, delivering medications
- » Handling what clinical teams don't want to do

You may miss the gift!



Golden Rules for Employing Peer Support

- » Hire enough to “feel” their presence.
- » Ensure they have received training.
 - » *Require certification documents at interview.
- » Orient to role and responsibilities.
- » Set high expectations.
- » Treat them as employees, not peer support employees.
 - » A **person** who has a job...not a **patient** who happens to work.
- » Work with **all** employees in a strengths-focused manner.



Working from Lived Expertise

- » Be mindful—many others we work with have lived experience.
- » Mental health challenges and substance misuse know no income, intelligence, or education level.
- » RI International seeks providers, nurses, and therapists with lived experience, not just peer specialists.
- » Training and education specific to peer support differentiates peer specialists from other team members with lived experience.

“I could NEVER talk about my depression at work.”



Peer Support at RI International



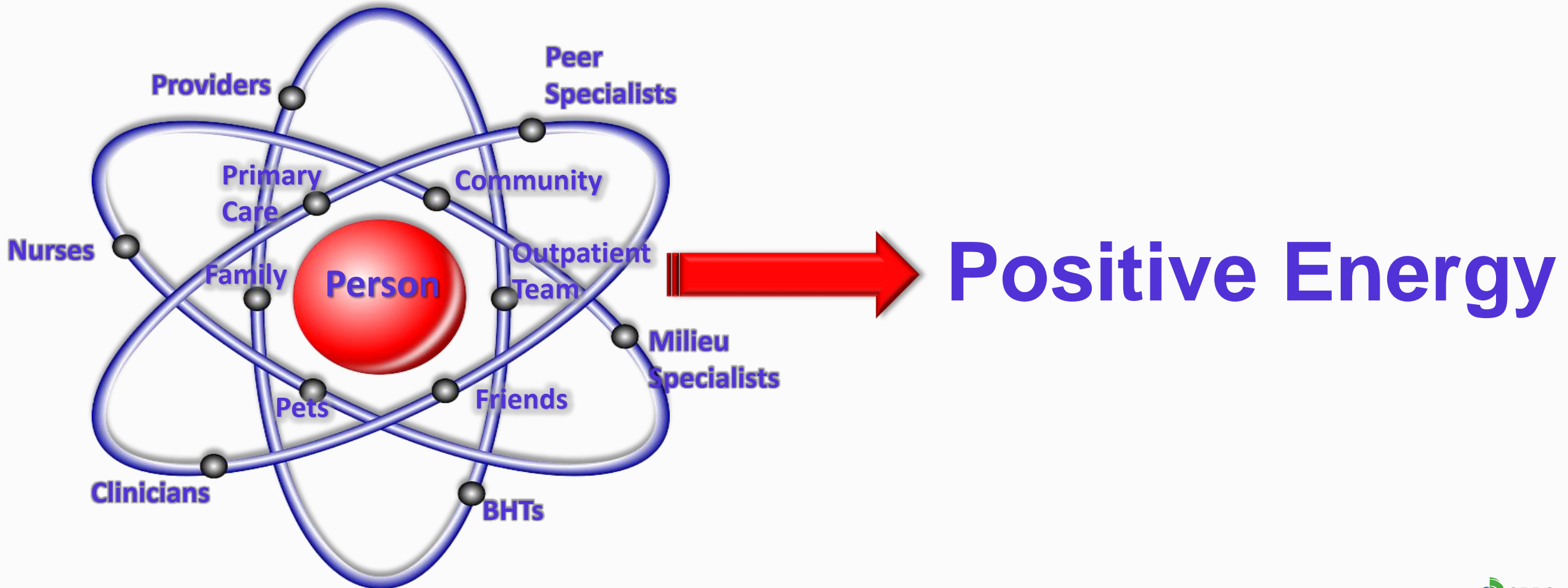
Campus of
Connection©

- » Community-based outreach and engagement to individuals who are homeless—especially during the pandemic
- » Transition from crisis centers, the justice system, and hospitals
- » Providing wellness and recovery classes and groups
- » Transitional living services
- » Crisis respite services
- » Temporary housing
- » Permanent Supportive Housing
- » Job development and employment support
- » Peer Support Training and continuing education
- » Consulting
- » Whole health peer support
- » Medication-assisted treatment (MAT) support and outreach into hospitals
- » Crisis receiving centers 23-hour retreat model
- » RI International trademark Living Rooms

Peer Specialists in Crisis Centers?!?!

- » Should peer supporters work in places where people may be treated against their will?
YES!
- » Assisted outpatient treatment (outpatient commitment) causes people to be brought to crisis centers if they miss an appointment or are refusing their medication, because they are under court order. This creates distress for people.
- » Peers are helpful to people who have an interaction with police due to their substance use or mental health issues—peers help create **HOPE**.
- » Where else do peer specialists need to be?

RI International Calls this Integration of Peer Support and Clinical Care... **Fusion**



Behavioral Health is at a Pivotal Point

The old system:



The new system:

- » Stabilization in a short stay center, hospitalization only as necessary, return to the community and home as soon as possible.
- » Involve police only when there is danger; jail or hospital are not the only options.
- » **Someone to call:** 988 for behavioral health crisis support.
- » **Someone to come to you:** Mobile teams with a clinician and a peer supporter.
- » **Somewhere to go:** Crisis centers—the right care, by the right people, at the right time.

Human Rights

Creative responses are needed that foster therapeutic relationships based on trust and empowerment, in ways that avoid the pitfalls of the past.

This statement seems like it is a prescription for peer support!

– Dr. Dainius Puras and Dr. Piers Gooding

Peer Support Strength

“I get where you are...I really get it.”

Anyone who has worked with peer supporters understands their unique strength of building almost immediate trusting relationships. The people they serve know—their peer supporters have been *there*.



I Have Been There

“I understand the journey.”

Having “been there” means that the person understands the distress felt, the helpful and not helpful effects of medication, the experiences of crisis, the losses that occur for many people, the way that we have to hide our challenges sometimes...



There IS HOPE!

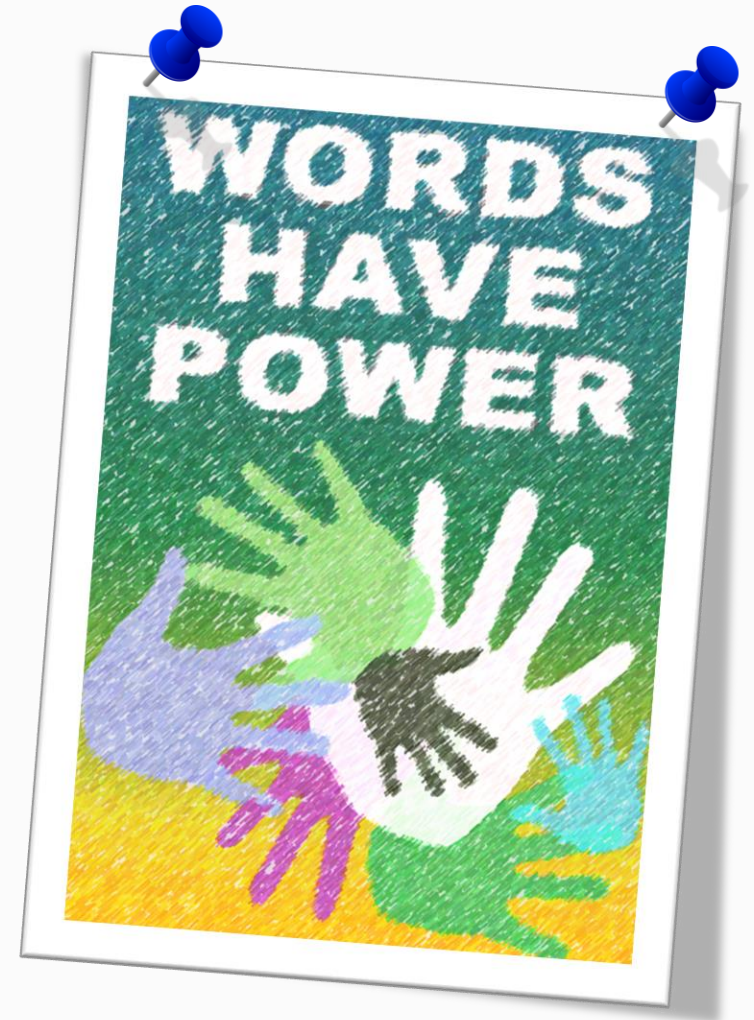
The unique gift of peer supporters is that they know that things can change, turn around, get better, and that people can live “a satisfying, hopeful, and contributing life even within the limitations caused by illness,” as Bill Anthony said.

If you can do it,
so can I!



When Teams Work with Peer Supporters:

- » The mindsets of the past that believed recovery was not possible are challenged.
- » The almost immediate relationship and trust peers build can be “bridged” to the rest of the team.
- » Language used about the people being served changes.



RI International's History of Peer Support

- » Developed a curriculum to train peer supporters in 2000
- » Needed to train peer supporters for our teams
- » Training is in its sixth edition
 - » Continuous updating for the past 21 years
 - » Trained over 15,000 peer supporters in the United States, Canada, England, Scotland, Ireland, New Zealand, Singapore, and Czech Republic
 - » Thousands of veterans through our contracts with the Veterans Administration
- » We added peer support to our crisis in-home service (a clinical service) in 2001
- » Peer support in every program, including crisis centers, by 2003

Overcoming Challenges

- » Clinical staff were concerned that they would need to manage the symptoms of the peer support staff, but this did not occur and peers were trained.
- » Hospital staff were resistant and once wanted a peer worker to wait until all **patients** went to dinner before they let them off the floor...even though they worked there, and it was the end of their shift.
- » Clinician's dilemma...



If they only see me when I am unwell, they don't know I am well most of the time

Some Folks Exited the Train

- » That was sad but okay because we were moving forward with bringing peer supporters onto our teams, and we have never looked back.



Sustainable Peer Support...

- » Peer Supporters must be trained and credentialed as defined by the state where they are employed to be able to pull down Medicaid dollars.
- » Organizations should receive training on what peer support is and is not.
- » Staff with lived experience, or without lived experience who will be supervising, need training to understand how to bring out the best in their peer support teams.
- » Prepare the way for peer supporters and you will have a better experience.

Sustainable Peer Support (continued)

- » Some peer programs are funded through the state or through grants without Medicaid dollars.
- » Medicaid dollars can help sustain a peer workforce.
- » U.S. House of Representatives: H.R. 8206, the Promoting Effective and Empowering Recovery Services (PEERS) in Medicare Act of 2020 Representatives Judy Chu (D-CA) and Adrian Smith (R-NE).

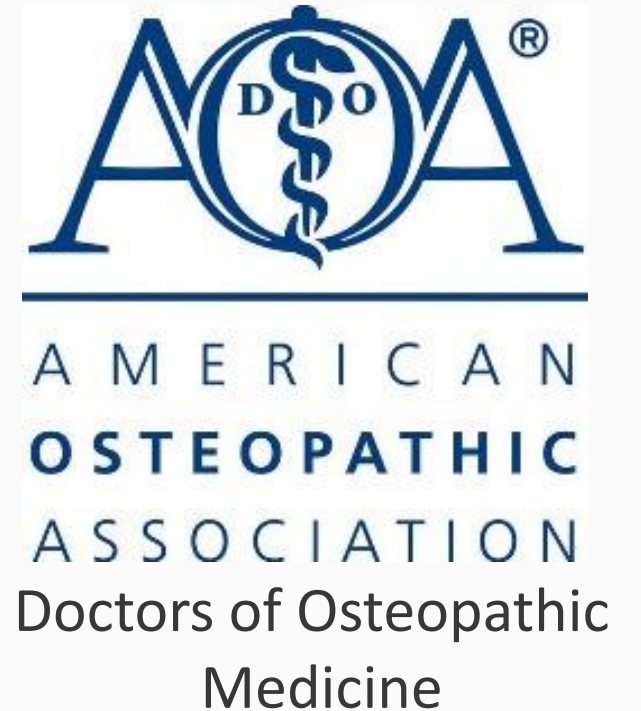
Challenges for New Provider Team Members in Medicine Are Not New



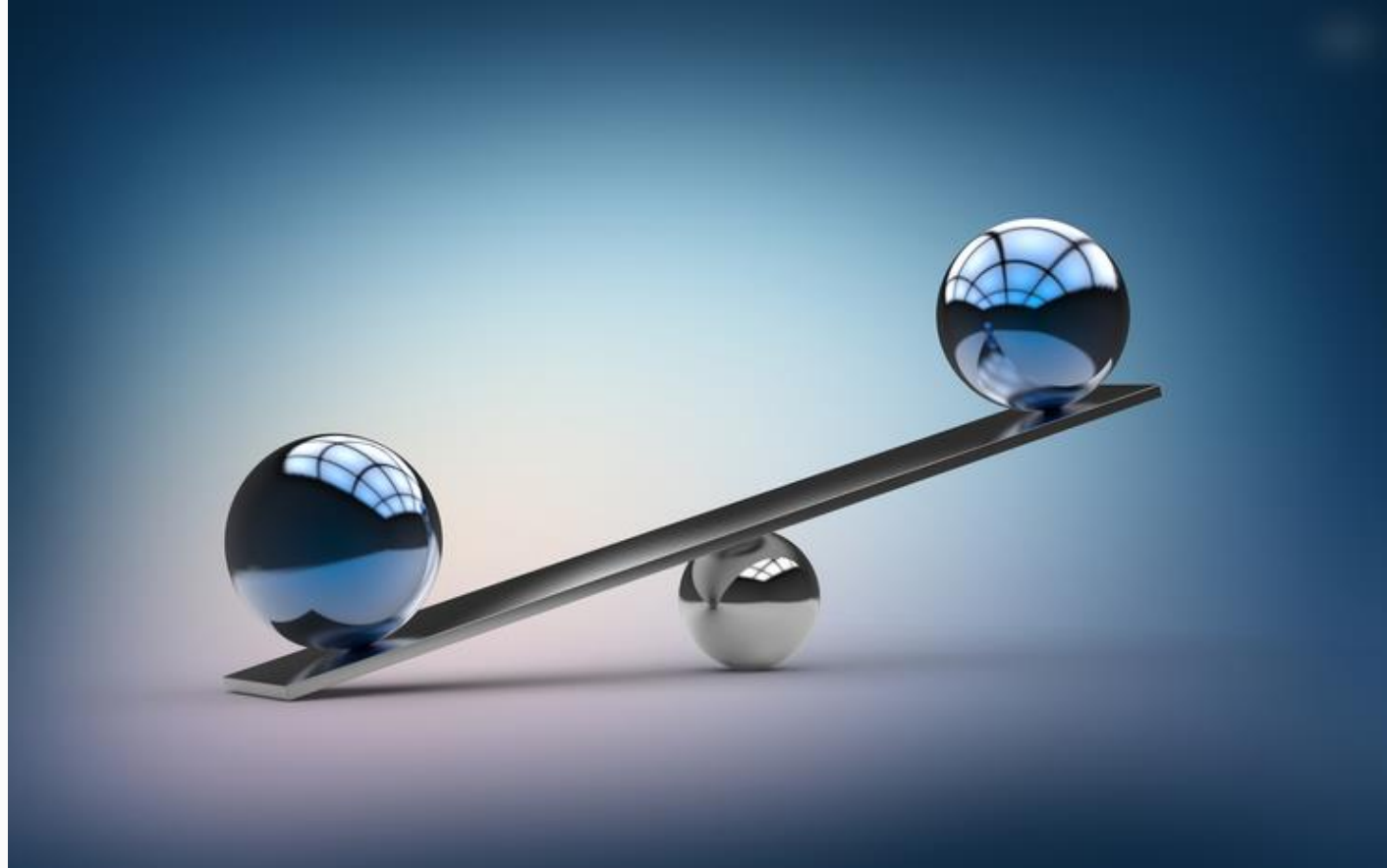
Nurses



Midwives



Tipping Point





Using the Q and A box: Share one key takeaway from the presentation.

Presenter



Tony Stelter, MHR, C-PRSS, LPC



THE VALUABLE ROLE OF LIVED EXPERIENCE

Tony Stelter, MHR, C-PRSS, LPC

Director of Recovery Supports

Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)

The Valuable Role of Lived Experience

- » Creating a culture of recovery
- » The value of lived experience in the workplace
- » “Warm hand-offs”

The Shift to a Recovery-Oriented Service Model

Maintenance

Stabilization

Disease/Disability

What's Wrong?

Staff Driven Services

Staff-Consumer Hierarchy

Mental Health

Social Isolation

Compliance

Dependence

Recovery

Resiliency

Wellness/Strengths

What's Strong?

Consumer Driven Services

Staff-Consumer Partnership

Whole Health

Social Inclusion

Engagement

Interdependence



Recovery Competence

What is my organization's "Recovery Competence?"

- » Person-centered?
- » Strengths-based?
- » Stigma?

Some thoughts on increasing that competence:

- » Employ and Deploy Peer Support
- » Annual training for all staff on the value of peer support and its role
- » Specific training for those that supervise peers on that role
- » "Traditional" providers shadowing peers
- » Peers having a valued voice and seat at the table

Advocate

One of the most important roles of a peer is to advocate for the client.

Peers can be a voice for the client.

Peers work with clients to empower them to advocate for themselves.

Advocate for the Peer Role



When implementing peer support, it is important for you to be an advocate for the peers and their roles in the program.

- » Ensure peers have a voice and a seat at the table.
- » Ensure their voice and seat is valued.
- » Be aware of stigma, stigmatizing language, and stigmatizing practices.
- » Support a person-centered, trauma-informed, and recovery-oriented environment.
- » Provide ongoing and consistent support and supervision to peer support staff.
- » Promote peer recovery support staff.
- » Provide continuing training, support, and education to all staff on the peer role.

My Story

PRE- RECOVERY

- » Low self-worth
- » Depression
- » Opiate addiction
- » Suicide attempt
- » Self-destructive behavior

RECOVERY

- » Worthy
- » Loving father
- » Great career getting to give back and help others
- » Positive relationships
- » Overall wellness:
 - » Quit smoking
 - » Running marathons

And more...

Experience

- » 10 years working in behavioral health
- » Started as a PCA (Mental Health Tech) at Children's Recovery Center
- » PACT-COCMHC
- » Consumer Advocate
- » Community Response Team Lead, Crisis Center
- » Assistant Director, Crisis Center
- » Director of Recovery Supports
- » Lived Experience and Supervision of PRSSs
- » C-PRSS and LPC

Being a Professional with Lived Experience

- » Normalizes
- » Dispels Myths
- » Increases Recovery Competence
- » Busts Stigma
- » Perspective
- » Culture

What is the potential of having professionals with lived experience in non-behavioral health settings?

Peer Recovery Support Closing the Gap “Warm Handoffs”

Closing Gaps in Care

What is a gap in care?

- » The space between levels of care
- » The missing connection between a person and their care provider
- » A time when individuals can relapse
- » A time when individuals are most at risk of suicide

Source: National Action Alliance for Suicide Prevention, 2019

Transitioning from Inpatient Psychiatric Care

For individuals with a history of suicide risk, the time after discharge from inpatient psychiatric care is a critical gap to close.

- » In the first week after discharge, the suicide death rate is 300 times higher than for the general population.
- » In the first month after discharge, the suicide death rate is 200 times higher than for the general population.

Source: National Action Alliance for Suicide Prevention, 2019

The Old Way...

- » A consumer is admitted into inpatient hospitalization or a crisis stabilization unit.
- » Consumer is a passive participant in their treatment and treatment team (medical model).
 - » Clinician dictates course of treatment. Consumer has little to no say in treatment goals.
- » Once consumer is “stabilized” they receive a prescription of medications and a referral to a local community mental health center.

Didn't they have a referral?

- » When individuals aren't allowed to be active in their treatment there is little "buy-in."
- » When there is no connection individuals don't have a reason to engage.
- » The unknowns:
 - » How can they help me?
 - » They don't even know who I am.
 - » I don't know what to do if I do go or what would happen.

The Better Way

Person-Centered Treatment (Recovery-Oriented System of Care)

- » Least restrictive environment.
- » If at all possible, the consumer is kept in an outpatient setting, using CAMS or another EBP.
- » If the risk is too high, a consumer enters inpatient hospitalization or a crisis stabilization unit.
- » The consumer is the expert on themselves and is the head of their treatment team.
- » The consumer is an active participant, setting their own goals and collaborating on their treatment plan.

Bridging the Gap

Begin discharge planning from the start!

- » Include the outpatient provider in the discharge planning, which includes a peer.
- » The peer from the outpatient provider should start building a connection with the consumer immediately and even participating in the treatment team process (ROI and MOU) to ensure everyone understands the consumer's needs and goals.
- » The consumer, treatment team, and outpatient provider work together on a person-centered discharge plan that meets the needs and goals of the consumer.
- » The outpatient peer maintains communication with the consumer and assigned inpatient peer throughout the duration of the client's inpatient stay.

How is this working for ODMHSAS?

In Fiscal Year 2020, those discharging from inpatient or crisis services:

- » 83% had follow up within 7 days.
- » 78% did not re-admit to inpatient/crisis within 6 months.
- » 81% were engaged in treatment within 45 days.

Source: Oklahoma Department of Mental Health and Substance Abuse Services



Using the Q and A box: Share one key takeaway from the presentation.



Questions?



FOR MORE INFO

Visit zerosuicide.edc.org to learn more about Zero Suicide.

Join the Zero Suicide listserv at go.edc.org/ZSListserv



Resources

Suicide Prevention Resource Center:

www.sprc.org

Engaging People with Lived Experience: <https://sprc.org/keys-success/lived-experience>

National Action Alliance for Suicide Prevention:

www.actionallianceforsuicideprevention.org

The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience:

<https://theactionalliance.org/resource/way-forward-pathways-hope-recovery-and-wellness-insights-lived-experience>

Lived Experience Zero Suicide Website Resources:

<https://zerosuicide.edc.org/search/node?keys=lived+experience>



References

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<https://doi.org/10.1002/wps.20599>

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5. Click the CLAIM button.



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Thank you!

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