A PEER SUPPORT RESPONSE TO THOUGHTS AND FEELINGS OF SUICIDE

ALTERNATIVES TO SUICIDE PEER SUPPORT GROUPS

Mental Health Academy on line presentation 12 April 2019

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RECOVERY MATTERS

Improving mental health systems

LEARNING OBJECTIVES

- Understand the constraints of the current suicide prevention system
- Review some of the myths and research about suicide
- Understand the peer to peer approach
- How this is being introduced in Australia

LIVED EXPERIENCE AND PEER SUPPORT

- Roses in the Ocean is a key organization in Australia which is harnessing lived experience as an education force in the suicide prevention sector

http://rosesintheocean.com.au/

- They define lived experience as . . . **…***having experienced suicidal thoughts, survived a suicide attempt, cared for someone who has been suicidal, or been bereaved by suicide.*
- Rose House in the US : …Peer Support refers to the role of a person with lived experience using that experience directly to support another person who is experiencing the same distress

PEER TO PEER SUPPORT

What is a peer?

A peer is a person with his or her own lived experiences with mental health conditions, psychiatric labels, emotional issues, and/or trauma histories. A peer is a person who has made significant progress working towards his or her own recovery… and who wants to help others in similar need. http://rosehousererspite.org/

Peer to peer support is provided by peers without clinical intervention.

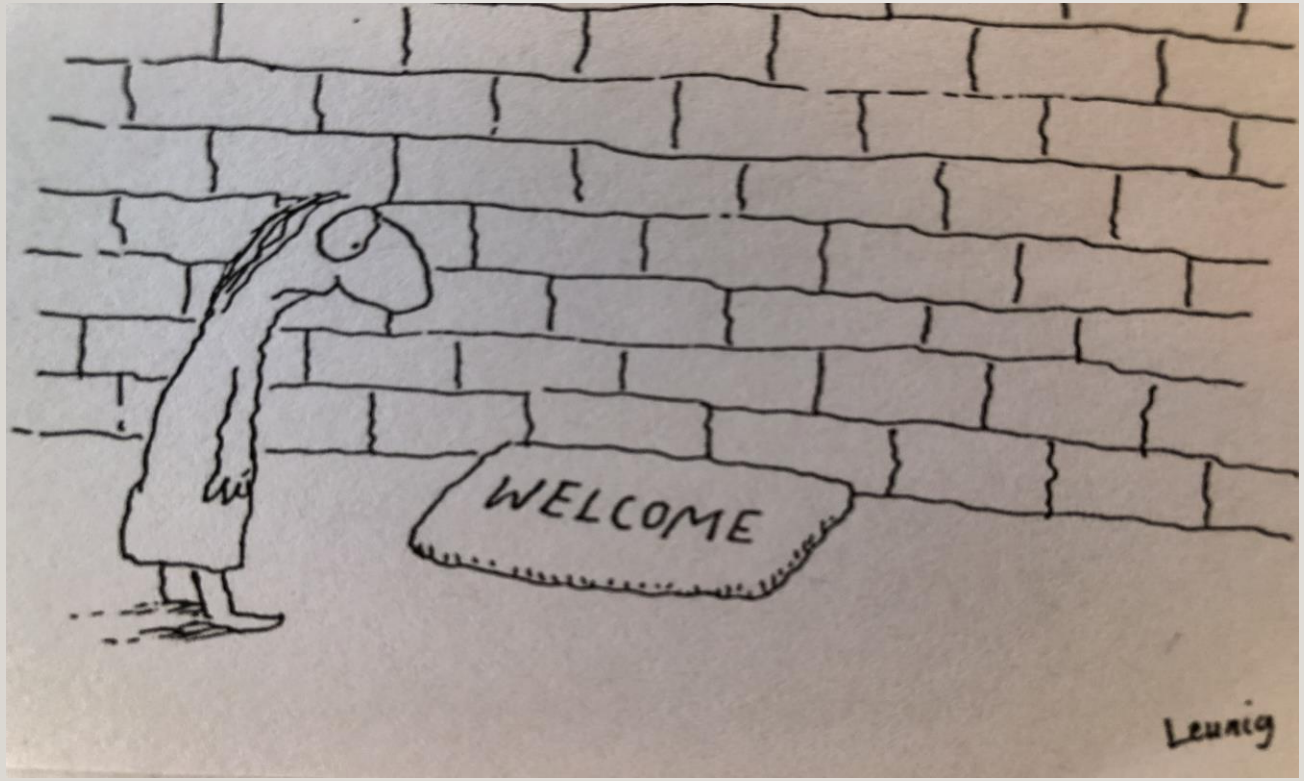
THE CURRENT SYSTEM

- Assumes knowledge lies almost exclusively with professionals
- Is based on a risk assessment and diagnostic approach
- Little emphasis on early intervention and prevention
- Poorly targeted expenditure
- Some potential change with the 5th Plan

WHY INTRODUCE A NEW STRATEGY FOR SUICIDE INTERVENTION?

- What we are doing isn't reducing the rate of suicide
- There is a need to change the narrative
- Our approach to what constitutes evidence blocks important input
- As researchers and service providers need to remember our origins in the community
- New approaches can be complementary and fill existing gaps

PROFESSIONALS ON TAP NOT ON TOP



THE ACES STUDY

- The Adverse Childhood Experience Study https://acestoohigh.com/2012/10/03/the-adverse-childhood-experiences-study-the-largest-most-important-public-health-study-you-never-heard-of-began-in-an-obesity-clinic/#comments

ACES findings on suicide:

- Only 1% of those with and ACES score of les than 4 had attempted suicide
- Almost 20% with and ACES score of 4 or more had tried to end their life
- Someone with and ACES score of 4 or more was 1220% more likely to attempt suicide than someone with and ACES score of 0. (Nakazawa 2015)
- The question becomes "What happened to you" Not "What's wrong with you".

MYTHS OF SUICIDE

Myth # 1. Talking about suicide is a bad idea

- Talking shows you care and will share the pain
- Talk About It campaign alliance
- Deep listening not risk assessment

MYTHS OF SUICIDE

Myth # 2. We should use risk assessments

Dr Matthew Large University NSW School of Psychiatry

…it is simply not possible to predict suicide in an individual patient, and any attempt to subdivide patients into high-risk and low-risk categories is at best unhelpful and at worst will prevent provision of useful and needed psychiatric care…

https://www.mja.com.au/journal/2013/198/9/suicide-risk-assessment-where-are-we-now

Researchers report that 60% of people who died by suicide denied having suicidal thoughts to medical professional (McHugh et al UNSW research January 2019)

MYTHS OF SUICIDE

Myth # 3. We will be liable

- **Fear of litigation**
- **Susan Stefan: Rational Suicide, Irrational Laws**

Examining Current Approaches to Suicide in Policy and Law

American Psychology-Law Society Series_ April 2016

- These are self referrals

MYTHS OF SUICIDE

Myth # 4. **Forced hospitalization helps people**

- …feeling of powerlessness dominated my experience of mental health services. And this feeling was at its worst when I was sectioned. Sectioning replicated aspects of the traumatic experience that initially caused my suicidal crisis. I felt trapped, captive and utterly out of control. I couldn't escape. . .Joy Hibbins, Suicide Crisis Centre (U.K.)
- Elevated suicide rates can last for up to two years after hospitalization. People learn to stop talking about suicidal thoughts.

Qin P, Nordentoft M. Suicide risk in relation to psychiatric hospitalization: evidence based on longitudinal registers. Arch Gen Psychiatry 62: 427-432

MYTHS OF SUICIDE

Myth # 5. Suicidal people must be mentally ill

- Suicidal thoughts and feelings are not always connected to a diagnosed mental health problem. There are many situational factors that can contribute to suicidal thoughts and ideation.
- Suicidal people become suicidal when they are in unbearable psychic pain. Suicidal people often believe that their psychic pain is greater than that of the average person. Suicide is seen as an escape. The suicidal person disconnects from memories of loved ones.

MYTHS OF SUICIDE

Myth # 6. Suicide prevention is the aim

We can adopt a life promoting approach rather than a risk averse approach, and respond to the distress rather than to a perception of risk

- When you say you want to kill yourself, what do you mean by that?
- What is leading you to the point of wanting to die?

WHY PEER SUPPORT?

- Emerging and evolving workforce in mental health services
- More effective engagement, personalised service(empowerment)
- reduction of stigma (Gallagher and Halpin 20140
- Reduction in hospital admission rates (Health Workforce Australia 2014)
- Produce outcomes similar to non peers (Pitt 2013)
- Feelings of acceptance, belonging, hope, motivation, reduced isolation (Bell et al 2014)
- Benefits to peer workers, services and service system, families and carers (Bell et al 2014, O'Hagan 2011, Kippax 2013, Mendes 2014)

PEER SUPPORT IN SUICIDE PREVENTION

- "The role of Peer Support in Suicide Prevention"

  Paul N Feiffer MD, 13 July 2015 HSR & D Cyberseminar

https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/video_archive.cfm?SessionID=989

- Peers for Valued Living (PREVAIL)

Development and Pilot Study of a Suicide prevention Intervention Delivered by Peer Support Specialists

Pfeifer et al Online First Publication, November 1 2018.

http://dx.doi.org/10.1037/ser0000257

PEER SUPPORT IN SUICIDE PREVENTION

ZERO SUICIDE AND PEER SUPPORT (USA)

- PEER TO PEER SUPPORT IS AN EVIDENCE-BASED PRACTICE
- PROMOTES CRUCIAL PROTECTIVE FACTORS SUCH AS CONNECTEDNESS AND HOPE
- PROMOTES RECOVERY AND RESILIENCE
- PROMOTES CHOICE AND VOICE IN TREATMENT
- CHALLENGES NEGATIVE STEREOTYPES

THE GAP THAT EXISTS IN OUR SYSTEM

- Lack of peer to peer support -There are insufficient non clinical alternatives - role of peers is underplayed
- The need for listening rather than assessing – peer to peer responses
- The failure to understand “psychache”. (Shneidman: The Suicidal Mind 1985)

ORIGINS OF THE "ALTERNATIVES TO SUICIDE" APPROACH?

- Based on the Hearing Voices peer support approach to psychosis
- Western Massachusetts Recovery Learning Community – peer run community group
- Impact of system response to requests for help for feelings of suicide
- Creating a safer space for people to talk about their feelings of suicide

HOW DOES THE ALTERNATIVES TO SUICIDE APPROACH WORK

- Peers only (Lived Expertise) – either have made an attempt or have ideation
- Self referred, no formal system referral process
- Two facilitators, both Peers, trained in the approach
- No clinicians unless they are there as peers (lived Expertise)
- No risk assessment
- Safe non judgemental environment
- Ninety minute sessions in non clinical environment
- Referral to other services only with the person's permission

THE ALTERNATIVES TO SUICIDE PEER TO PEER SUPPORT GROUP PHILOSOPHY

- RESPONSIBILITY TO – NOT FOR, OR OVER
- HONOURING EVERYONE'S UNIQUE JOURNEY
- EMPOWERING THROUGH SHARED EXPERIENCE
- COMMUNITY BUILDING
- MEANING MAKING
- SOCIAL JUSTICE FOCUS
- CHALLENGING PRECONCEIVED JUDGEMENTS

THE GROUPS ARE LIFE PROMOTING

INTRODUCING THIS APPROACH TO AUSTRALIA

- MercyCare February 2017 showcase in Western Australia
- Formation of a Steering Committee in August 2017 and the March 2018 visit to Perth, Melbourne and Sydney – Facilitator training
- Evaluation outcomes
- Suicide Prevention Australia National Conference July 2018
- Steering Group now led by HelpingMinds in WA with MercyCare involvement
- Proposal for 2019/20 visit

INTRODUCING THIS APPROACH TO AUSTRALIA

- City Rotary, Perth
- Lotterywest application – suicide prevention peer workforce focus
- ConnectGroups supervision support
- Steering Group enlarged
- New groups emerging

CURRENT GROUPS

- **DISCHARGED –Alternatives to Suicide group – Transfolk, Perth, Western Australia**

  since May 2018

  DISCHARGED - Deserving of Inclusion, Support, Community, Hope, Authenticity, Respect, Growth, Empathy, and Determination. - email Deservingof.ISCHARGED@outlook.com

- **Alternatives To Suicide Inner West Sydney** since September 2018
  http://www.offthewall.net.au/contact-us/

FURTHER INFORMATION

https://www.mercycare.com.au/alternatives-to-suicide

http://www.westernmassrlc.org/alternatives-to-suicide

http://www.sprc.org./resources-programs/manual-support-groups-suicide-attempt-survivors

https://www.youtube.com/watch?v=RL7dqK_MACE&feature=youtu.be

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THANK YOU