The peer specialist: possibilities for the recovery of suicidal care consumers

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The role of peer specialists in suicide prevention is promising, but the professionalization of this field currently is underdeveloped. To achieve its potential regarding suicide prevention, it is imperative that peer specialists* role and...

Ethical review	Approved WMO
Status	Recruitment stopped
Health condition type	Suicidal and self-injurious behaviours NEC
Study type	Observational non invasive

Summary

ID

NL-OMON45246

Source
ToetsingOnline

Brief title
The peer specialist

Condition

- Suicidal and self-injurious behaviours NEC

Synonym
suicide self harm

Research involving
Human

Sponsors and support

Primary sponsor: Rijksuniversiteit Groningen
Source(s) of monetary or material Support: ZonMw

Intervention

Keyword: Peer specialists, qualitative research, suicide prevention

Outcome measures

Primary outcome

NA: qualitative study: the view of participant on what unique value for the recovery process of suicidal care consumers can be derived from current initiatives and the (future) integration of peer specialists on the one hand? What potential risks could emerge on the other hand, and how could these risks be successfully addressed?

Secondary outcome

NA

Study description

Background summary

Following the initiative of care consumers who felt that their voice regarding their care was not heard by mental health services, a peer specialist movement started in the United states in the 90s and has since expanded to Europe (Doughty & Tse, 2010). The peer specialist movement proposes a holistic view of care consumers (e.g., clients or patients) instead of a *narrow* (psychiatric or medical) view of symptoms; it advocates a person-centered, integrated mental healthcare delivery model, in which the consumer*s voice is taken seriously (Cabral, 2014; Clossey, 2015).
The emergence and availability of peer specialists with a history of suicidality (i.e., suicide attempts and/or suicidal ideation) who work with suicidal care consumers is a more recent phenomenon in this context. In the United states, the Suicide Attempt Survivor Movement was launched within the America Association of Suicidology, aimed at the improvement of care provided to suicidal care consumers (2014). The reason for this movement was that care consumers are frequently dissatisfied with their treatment (Peterson & Collins, 2015); for instance, health care staff is perceived as unempathetic and sometimes as judgmental, and care consumers* needs are not fully met (Cerel, Curier, & Conwell, 2006; Lindgren, 2004). Furthermore, healthcare staff often

appear to focus exclusively on suicide risk assessment (Segal-Engelchin et al., 2015), while care consumers appreciate a caring conversation (Ross, Kelly & Jorm, 2014). Suicidal care consumers also observe discomfort, taboo, and fear around healthcare staff discussing suicidality (Lindren, 2004).
The rationale behind the suicide survivor moment, having peer specialists involved in suicide prevention (Thomas, 2011) is their anticipated unique value in helping fellow care consumers with their recovery from suicidality. The unique contribution of peer specialists in suicide prevention is expected to emerge as a result of shared experiences with suicidality and shared adversities in life, mutual recognitions of stigma, and shared challenges of communicating with healthcare staff and/or family and friends about suicidality. Due to their own recovery process, peer specialists can be a source of inspiration or role models for suicidal care consumers (Salvatore, 2010).
Despite this potential of peer specialists, the employment of this group in mental healthcare services in the Netherlands is still in its early stages. However, due to recent developments, an increase of the number of peer specialists can be expected shortly. Further professionalization of peer specialists is supported by the Dutch Association of Mental Health Care that requested the addition of peer specialists to the list of official mental health professions (VZA), which emphasizes this conviction. Therefore, the role of the peer specialist is increasingly important.
A general professional profile of the peer specialist (Van Bakel et al., 2014) has been outlined recently in the Netherlands, yet it has no reference to suicidality or suicide intervention skills. However, stakeholders with whom we consulted (see project team and collaboration partners) acknowledge the importance of peer specialists in suicide prevention. For instance, during several consumer-led recovery training sessions (e.g., WRAP), trainers acknowledged their difficulty in addressing suicidality when this topic emerged. In a similar vein, students enrolled in the degree of peer specialist who discussed their (previous)

suicidality in class, experienced that many educators lacked expertise and knowledge concerning this topic. Suicide prevention is not part of the curriculum for peer specialists, although suicidality and self-harm is frequently a topic of discussion in working with suicidal care consumers. Risks may exist when peer specialists work with suicidal consumers without adequate training, supervision, or aftercare, as working with suicidal care consumers can be burdensome. It also requires explicit knowledge about (juridical) responsibilities and collaboration with other mental healthcare professionals.
The core foundations of the general peer specialist model (i.e., recovery assisted by peers, Clossey et al., 2016; Johnson et al., 2014) is applicable to suicide peer specialists and connects well with effective approaches to suicide prevention (Van Hemert et al., 2012). We propose that peer specialists who have recovered from suicidality can offer hope, support, and an opportunity for re-connection to care consumers who are struggling with suicidality*aspects that are proven to be crucial in suicide prevention (Alexander et al., 2007;

Herringstad & Biong, 2010, Oliffe et al. 2010). Peer specialists are well equipped to suggest care improvements for suicidal individuals, and hereby prevent suicide. However, further professionalization in this context is needed.

Study objective

The role of peer specialists in suicide prevention is promising, but the professionalization of this field currently is underdeveloped. To achieve its potential regarding suicide prevention, it is imperative that peer specialists* role and professionalization in mental health services are strengthened.

Research questions

How can the unique value of peer specialists with a history of suicidality who (intend to) work within mental health services be utilized to reduce suicidality among care consumers?

How can the professionalization of peer specialists be strengthened and potential pitfalls be addressed in relation to suicide prevention in mental health services?

By professionalization, we refer to:
* training (e.g., understanding the suicidal process and recovery)
* curriculum development on suicidality
* resources for peer specialists in suicide prevention
* role development and role clarity
* supervision and aftercare

The professionalization of the peer specialists* role in suicide prevention needs to be strengthened at two levels:
Level 1. Peer-to-peer support
Level 2. The institutional level, including staff and policies

Subquestion A:
What need do stakeholders perceive for initiatives from peer specialists with a history of suicidality in relation to mental health services, and which initiatives already exist in the Netherlands and internationally?

Subquestion B:
What unique value for the recovery process of suicidal care consumers can be derived from current initiatives and the (future) integration of peer specialists on the one hand? What potential risks could emerge on the other hand, and how could these risks be successfully addressed? The unique value of peer specialists refers to their experiential knowledge of suicidality, and if their role is strengthened, benefits in suicide prevention include recovery, peer support, the consumer perspective on care for suicidal people, suicide

intervention skills, and psycho-education. Next, the risk analysis is focused on risks that emerge for suicidal consumers, peer specialists, and mental health institutes and their managers. These risks include (a) the mental burden of supporting suicidal peers; (b) issues of confidentiality, particularly in relation to suicide risk taxation; (c) the complexity of dual relationships between staff and peer specialists and those they attend to (consumers); (d) resistance among traditional professionals against suicide prevention by peer specialists.

Study design

Due to the early stage of involving peer specialists with a history of suicidality in Dutch mental healthcare, we have chosen an exploratory and qualitative research approach that interconnects stakeholders in the field. Two research methods are applied: a review of international and national *grey* literature and media, and focus group- and individual interviews.

Study burden and risks

The current research burden exists of a qualitative interview of approximately one hour. Participants will be thoroughly informed about the purpose and nature of this interview in advance. Although we will inquire after the suicidality of the participant for contextual and descriptive purposes, the main focus of the interview will be on the persons expectations, needs and experiences of peer specialists and how they can help in the recovery process of suicidality. Previous research has shown that discussing suicidality with vulnerable groups and suicidal persons has no iatrogenic effects and can even alleviate stress associated with suicidal ideation (Biddle et al., 2013, Dazzi et al., 2014; Huisman & Kerkhof, 2017). Therefore, the burden of participating in the current research is considered to be minimal and risks are negligible. Participants can terminate the interview at any time without explanation; the researchers are thoroughly trained in discussing the sensitive topic of suicidality, assess suicide risk and are able to make referrals to further help if necessary. Potential benefit of participating for participants is that they can contribute to the further professionalization of peer specialists and can voice their needs regarding the mental health care they are offered.

Contacts

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Trial sites

Listed location countries

Netherlands

Eligibility criteria

Age
Adults (18-64 years)
Elderly (65 years and older)

Inclusion criteria

Ten (former) care consumers with a history of suicidality who were in contact with a peer specialist
and:
Eight to sixteen (former) care consumers with a history of suicidality who were not in contact with a peer specialist

Exclusion criteria

acute suicidaliteit

Study design

Design

Study type: Observational non invasive

Masking:	Open (masking not used)
Control:	Uncontrolled
Primary purpose:	Health services research

Recruitment

NL

Recruitment status:	Recruitment stopped
Start date (anticipated):	01-05-2017
Enrollment:	18
Type:	Actual

Ethics review

Approved WMO

Date:	20-10-2017
Application type:	First submission
Review commission:	METC Universitair Medisch Centrum Groningen (Groningen)

Study registrations

Followed up by the following (possibly more current) registration

No registrations found.

Other (possibly less up-to-date) registrations in this register

No registrations found.

In other registers

Register	ID
CCMO	NL59877.042.17