New England (HHS Region 1)

MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Suicide Prevention Symposium
Proceedings

Greenfield, MA
June 17, 2019

On June 17, 2019, the New England Mental Health Technology Transfer Center (New England MHTTC) convened representatives from approximately 25 groups from the six New England states, to begin a dialogue on how best to integrate peers into suicide prevention efforts around the region. While the initial focus for the day was on the role of peers in supporting people through various transitions in care, the conversation quickly shifted to the role of peers more broadly in preventing suicide.

Part 1 | Welcome and Introductions

The symposium opened with welcome and introductions. Katie Volk opened the day by indicating that this meeting is the start of many conversations that the New England MHTTC hopes to facilitate on the topic of suicide prevention. She acknowledged that this is a personal topic for many, and that many of us bring passion, heartache, grief, and resilience to the work. Maria Restrepo Toro then provided an overview of the goals, objectives, and scope of the New England MHTTC. Katie Volk then led the group through an exercise entitled "Know Your Why," designed to help the group find common ground and root ourselves in why we do this work and how we sustain ourselves in the process.

Part 2 | Context

Larry Davidson provided the group with context about suicide and suicide prevention in the United States. He noted that a person's risk for suicide risk is fluid – a complex interplay between vulnerabilities, stressors, and distress. Having other people in one's life who care is critical and connection is a protective factor. During his comments, Larry described the environmental scan that MHTTC conducted in preparation for the symposium. The scan demonstrated that there is much work being done and that the role for peers in the suicide prevention space is still emerging. The New England region is well-poised to contribute to the field in this regard, as recovery and peer leadership is a core focus of the New England MHTTC and the New England region has extensive

knowledge, particularly with the presence of the Western Massachusetts Recovery Learning Collaborative.

Larry Davidson then introduced Michael Hogan, who served as a mental health commissioner in Connecticut, Ohio, and New York and chaired the 2003 President's New Freedom Commission on Mental Health. That report has been crucial in establishing recovery as the overarching aim of all mental health services. Larry noted that the symposium brings together Michael Hogan's two passions: recovery and suicide prevention.

New England MHTTC Principles

Part 3 | Keynote: Michael Hogan

Michael Hogan began by acknowledging that it is rare to have a convening this large that focuses on peers and suicide prevention across a region, stating that "To the best of my knowledge, this is the first meeting like this." He then described his personal and professional experience with health care systems and suicide. Recalling his experiences working as mental health commissioner in several states, Michael reflected that "I got frustrated with what was going on in suicide prevention when I was trying to run these systems...people were dying in our care. Lots of people were dying in our care. The numbers are stunning and staggering. And, so often at the end of the [case] review, it comes down to, 'He seemed okay,' or 'We did what we were supposed to do'" and that was the extent of the system's focus on preventing suicide for people while in the

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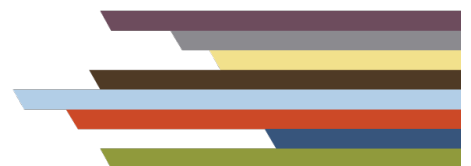
mental health care system. He began exploring how healthcare systems can do better by people who are suicidal, citing research that many people have had contact with the health care system (e.g., their primary care doctor) in the thirty days prior to dying by suicide. "These people had pain of some kind, physical, psychic, often both…So, they go to the one healthcare professional they trust. They don't have the words to articulate this pain, and what doesn't happen? They don't get asked (by the healthcare professional if they are in pain). So, they go there with the pain, they don't get any relief from the pain, and a month later they're dead."

Michael then continued by citing research from mental health systems about suicide prevention and noting the changes made in other fields (e.g., cardiology) to reduce mortality. "Reduction in smoking has done for heart disease, what a reduction in trauma would do for suicide. But, smoking is easier than trauma. It's also easier for our country, for lots of different reasons, to try to attack smoking, than it is to attack trauma." He noted that what systems should be doing is "leaning in" to identify people at risk, offer support and engagement, and "then, help the person develop their own plan – not our plan, their own plan – for safety and recovery." He then described ways to reduce access to lethal means of harm (e.g., access to firearms) and working with hospitals to treat suicidality (rather than only mental illness symptoms) with authenticity. He underscored that "isolation is poison…The things that are the most critical and effective in preventing suicide are precisely the kind of things that peers [can support]." He cautioned, however, that just because someone is a peer specialist does not mean that they are comfortable talking about suicide. Peers, like other providers, may need to develop those skills. Michael closed his talk by stating that suicide prevention is not just one person or one system's responsibility. Everyone must be involved – from hospitals to mental health facilities to communities – with peer involvement at every step of the process.

To view a recording of Michael Hogan's keynote, please visit www.mhttcnetwork.org/newengland.

Part 4 | Peers in Care Transition Roles: Experiences from the Workforce

During the next part of the symposium, four panelists discussed their experiences as people with lived experience and as peer specialists. The panel was facilitated by Livia Davis of C4 Innovations. Panelists included:

- Paul Hammer | Yale Program for Recovery and Community Health
- Karen Kiley | Beacon Health Options
- Valerie Lepoutre | NAMI Connecticut
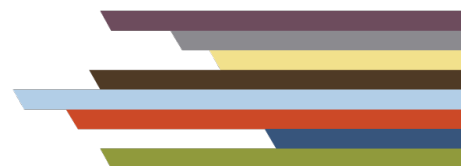
- Caroline Mazel-Carlton | Western Massachusetts Recovery Learning Community

What is working well in terms of peers supporting people through care transitions?

Panelists offered both philosophically and practically about what has worked well.

Emergency Rooms. It is helpful to have peer specialists embedded in emergency rooms, and for them to have strong relationships with the staff so that they bring peer specialists into the conversation with people early in their ER visit. People quickly realize peers won't be judgmental. Western Massachusetts Recovery Learning Community (RLC) has partnered with hospitals so that people can leave the hospital to attend Alternatives to Suicide meetings, then return to the hospital. It allows people an opportunity to be back in community with others.

> "I just want to say how grateful I am to be here in Greenfield today, which is the home of the longest-running Alternatives to Suicide group that meets in the world...I want to honor that lineage."
>
> – Caroline Mazel-Carlton, Western Massachusetts Recovery Learning Community

Keeping in touch and reaching out. Panelists spoke of the need to meet people where they are, literally and figuratively. Many of their programs are set up so that they can meet with people in diverse locations (e.g., home, park, court, bus, hospital). Beacon Health Options has the capacity for peers (using their work phones) to text with clients, which has been very helpful. NAMI Connecticut's peer-facilitated groups for young adults often meet to go hiking, listen to music, create art, or write – all ways to establish connection and health, while also taking the pressure off of the need to verbalize. They reach out to people through already-established community-wide events (e.g., Pride) and social media.

Quality of Communication. Peers can communicate with people in ways that clinicians cannot. They are perceived as far less judgmental. Western Mass RLC notes that in their program, people have a space to have conversations that they can't have anywhere else. They can speak freely, without fear of negative consequences or coercion. We have to acknowledge that for people who are contemplating suicide, it seems like a solution to a deep problem. To heal, we must address the root causes of what makes people want to leave the world. Why do people want to leave this world? We have to look at more than just mental health pathology; trauma and lack of resources play a role as well.

Risk Assessment Tools. People know how to answer these tools to get what they want or don't want. That's why the tools don't have predictive value. In peer-run programs, we often hear from people who say ""I stopped talking about suicide when X happened," or "I haven't mentioned suicide since Y happened." What we don't hear is that "I stopped thinking these thoughts." Peers can be extremely valuable in having these kinds of conversations.
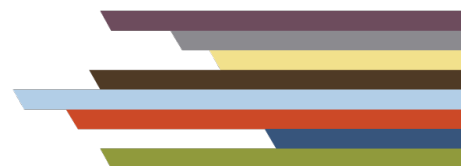
Coordinated Systems and Interventions. Panelists cited a few ways that systems are coordinating care for people who are suicidal and also noted a few interventions that have been helpful. For example, Beacon Health Options holds Community Care Team meetings, during which providers are able to communicate across departments/service types. Wellness Recovery Action Planning (WRAP) was also noted as helpful. Western Mass RLC runs a peer respite program called Afiya (a Swahili word meaning "wholeness"), which is open 24 hours a day, 7 days a week. It is entirely peer-run, with staff trained in Alternatives to Suicide and Intentional Peer Support (IPS). Others noted that offering grief support for people who have lost someone to suicide is critical, so people can talk about their pain and loss with others who really understand.

What types of support are needed for peers as they work with individuals in transition?

Peer specialists need a host of supports to do their work effectively.

Wages and funding. To truly value peer support, we have to value it financially by paying people living wages and offering funding for peer approaches to working with people.

Supportive workplace. Workplaces should be designed to be welcoming and supportive for peers. For example, being well-versed in ADA accommodations and having peers in diverse roles is helpful. Avoid tokenism. We need to create environments where multiple approaches are respected (e.g., psychiatry, social work, peers, etc.).

Shift in value systems. Peers often have a value system and approach that is different from that of clinicians and systems. They are often equipped to have conversations that others in the field are not able to have in the same way. We still have work to do to ensure that these approaches are equally valued and respected. For example, peers are sometimes told that they must have a clinician present when talking with people, which is antithetical to a peer approach.

Practicalities. Peers are always looking for new information/resources, especially at the community level. It is also helpful to have the ability to text people and have a well-run on-call system.

In addition to the above, panelists noted that transition periods are incredibly hard. To help mitigate those transitions, it would great for staff and peers to work more long-term with people.

After these initial conversations, the audience had an opportunity to ask questions.

Audience question: What does supervision of peers look like in your settings?

Panelists had a variety of perspectives and experiences concerning peer supervision. One noted that the peer role has unique and important values that differ from the

clinical model, so it doesn't make sense for clinicians to supervise peers. It can lead to frustration for both parties. Another noted that when peers and clinicians think of themselves as equals, there is an opportunity to learn from one another. No matter how the supervision happens, panelists agreed that "we need the people supporting us to be well-grounded in peer values." In particular, having people "at the top" of organizations embrace the values of the peer system is essential. Ideally, peers should play key roles at all levels of decision making.

Co-supervision – peer to peer supervision, clinical supervision. Although supervision of peer workers is not dramatically different from supervising other roles, there are specific competencies supervisors need, including knowledge of peer roles and practices (as opposed to knowledge about clinical practices), recovery-oriented values, and understanding the types of recovery support peer workers provide. Some health care agencies partner with peer-run organizations to implement co-supervision of their peer workers. This ensures the peer role does not get co-opted into becoming a clinical role, while also supporting integration with the clinical team.

Audience question: What are your perspectives on handling powerlessness and coercion?

Power differentials hurt people on both sides. Working in a clinical role is very difficult; it may force people to put up walls, rather than form connections (even though forming connections may be their "why"). NAMI Connecticut notes that their young adult peer group tells participants that, "You have the power within you. Coming to this group is using that power." To have a true conversation about power, we need people from the "big systems" to be in the room. Part of the peer role is often to encourage people to advocate for themselves – which is very hard when power differentials are significant.

Audience question: How can we integrate peer mental health workers with community health worker programs and others working on parity?

Peers don't look at diagnostics or pathology. Examining social determinants of health, including living wage, transportation, continuity of care, and stable housing, should be a part of the conversation at all agencies. When it is done well, peer roles always look at these factors. However, due to scope/mandate, some agencies consider these things and some don't or can't.

To view a complete recording of the panel, please visit
www.mhttcnetwork.org/newengland.
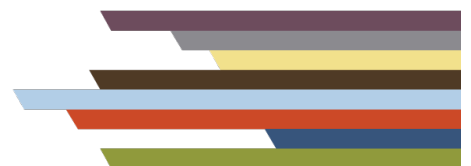
Part 5 | *Gone Too Soon*, by Paul Hammer

Paul Hammer shared a brief portion of his project *Gone Too Soon*, a play which features writings of people who have died by suicide, survived suicide attempts, and/or have lost loved ones to suicide. Hammer noted that "the supposition is that theater, along with other artistic forms of expression, can be powerful ways of communicating important points that are sometimes hard to convey effectively in other settings." The play includes excerpts from letters, eulogies, and other writings, as a way to celebrate people's lives. When performed in its entirety, the playbill includes information about suicide prevention. Post-show, there is time for questions and answers and when appropriate, the play will incorporate the experiences of people local to the performance.

Hammer concluded his presentation by singing portions of *Gracias a la Vida* ("thanks to life"), a song that is both a celebration of life and an acknowledgement of its sorrows. The composer is Chilean singer/songwriter Violeta Parra. "Parra was a major force in the Nueva Canción movement, which revived traditional folk music in Latin America and blended it with lyrics promoting social change," explained Hammer. She died by suicide in 1967. *Gracias a la Vida* is often performed by Joan Baez, whose 1967 album of Spanish language music bears the same name.

To view a complete recording of Paul's performance, please visit www.mhttcnetwork.org/newengland.

Part 6 | Carousels

In the afternoon, participants participated in a series of "carousel" conversations. Divided into four groups, each group moved from table to table to participate in brief conversations on certification and credentialing, peers supporting families after loss, New England partnerships, and learning collaboratives. These topics and the focus questions (see below) were identified through conversation with diverse organizations involved in suicide prevention work around New England and upon reflection of the mission, scope, and goals of the New England MHTTC. The notes from these carousel conversations are summarized below.

Certification & Credentialing (Livia Davis, facilitator)

The key questions presented to groups during this conversation were as follows:

- *What are the core skills for peers supporting individuals facing major transitions in or between primary and behavioral health services?*
- *What are the training considerations?*

- *What are the current certification, credentialing bodies and career pathways for peers with lived experience in the region and how would they intersect with this initiative?*
- *How do we ensure equity and inclusivity?*

The groups identified a number of core skills/trainings for peer working in suicide prevention:

- How to navigate the system and advocate for people. It is confusing and people get lost in it. Peers can help. This cannot be through a clinical process, though. It must be peer led.
- Some participants use specific models/training: WRAP, Alternatives to Suicide, Non-Violent conflict resolution, intentional peer support.
    - Alternatives to Suicide includes conversations about navigating extreme states, hearing voices, intentional peer support, and group facilitation.
- Comfort with conversations about suicide, death, etc.
- Forensic peer training (via SAMHSA)
- Some participants noted that peers may want specialty training (e.g., working with people who are elderly, gender non-conforming, veterans, incarcerated, etc.).
- Spirituality
- Boundaries
- Self-care
- Interpersonal skills, building rapport, trust
- Power dynamics
- Sometimes skills need to be un-learned (e.g., jargon, diagnostic focus, academic focus)

The groups also noted that the peer role needs to be defined clearly and that peers should lead trainings for clinicians.

Peers supporting families after loss (Jeffrey Hill, facilitator)

The key questions presented to groups during this conversation were as follows:

- *What are best practices in how peers can support families after loss, short-term and long-term?*
- *How do we ensure equity and inclusivity?*

Scope and Format of Support. Participant comments focused primarily on support groups as a way of facilitating peer support. Many participants indicated that loss survivors
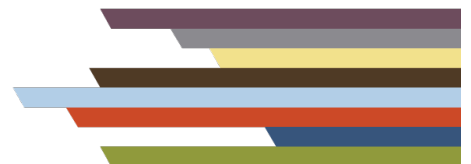
need their own group, distinct from groups that support people whose loved ones have attempted suicide. For example, family/friends of those who have attempted suicide should have a safe space to discuss their experiences and feelings, while also ensuring that these feelings do not to consume the person grieving a loss. A few people noted that sometimes having a mix of people (loss/attempt) can work well, although it requires delicate facilitation to ensure that those who are grieving a loss do not place guilt on those who are grieving/coming to terms with an attempt. Jeff mentioned similarity of overdose support groups: The parents who lost children started supporting parents who didn't lose their children to overdose. They had that in common, provided peer support. Participants also noted that sometimes, those who have lost someone to suicide are "held higher up" than those who have attempted.

Defining Peers. Participants discussed how best to define "peer." They noted that peers are those who connect around a shared experience. Often, people who have lost someone to suicide seek explanations for why their loved one died by suicide; while groups cannot answer those kinds of questions, they can support one another through the grief process. Defining peers seems to fall into three categories: survivors, family/friends who have lost someone to suicide, and family/friends of attempt survivors. Each of these groups may find solace and support in one another at times, and may also benefit from support by those only in "their" category. For example, participants noted that sometimes survivors of suicide feel guilty when discussing their reasons for attempting suicide with parents who lost their loved ones/children to suicide.

Ensuring Equity and Inclusion. Participants identified a number of strategies for ensuring equity and inclusion. They noted that every grief is difficult; it can be hard and often impossible to categorize people who are grieving. It is also important to note that there are often overlapping dynamics surrounding a death by suicide, including mental illness, socioeconomic factors, financial struggles, trauma, and substance use.

Noting that people have different beliefs based on religion, culture, and other factors is essential. It can be hard to have intense conversations about suicide when people have differing beliefs about life after death, loss, and reasons for suicide. Forming groups can be most supportive when people themselves decide that they want to grieve together – then the group can determine how and where that happens. For example, NAMI Connecticut formed a hiking group for young adults.

Stigma and discomfort. There is significant stigma around suicide and discomfort in discussing matters related to death. Our society is often not open to discussion while people are suffering and contemplating death by suicide. When/if someone does attempt or die by suicide, it is similarly often hushed or not discussed. Participants identified the need to foster conversation, in families, communities, among those who are in pain, and among those who are grieving. Organizations and programs are beginning to find ways for these "taboo" conversations to take place.
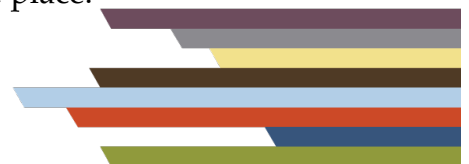
New England Partnerships (Maria Restrepo Toro, facilitator)

The key questions presented to groups during this conversation were as follows:

- *What opportunities for partnership and collaboration exist in New England?*
- *What could MHTCC do to help foster/support these efforts?*
- *How do we ensure equity and inclusivity?*

The carousels identified several opportunities for partnerships in New England including convening and/or offering resources, training, and technical assistance. They also made suggestions about the role of New England MHTTC and strategies for promoting equity and inclusivity.

Convening

- Organize focus groups with stakeholders to talk about suicide prevention
- Promote statewide meetings to talk about suicide prevention
- Promote meetings between health care workers to ask them what they know about suicide prevention; what they want to know; and how it is related to mental health
- Organize state meetings to talk about suicide prevention and invite expertise/lived experience to talk about the topic

Resources, training, and technical assistance

- Combine information about suicide prevention in New England.
- Share research about the topic.
- Share tools about suicide preventions.
- Link websites about the topic.
- Develop fidelity tools to work with suicide prevention.
- Offer training for supervisors about suicide prevention.

Support peer workforce

- Establish the peer's support role.
- Organize trainings for peers' support about suicide prevention.

Role of New England MHTTC

- Provide resources for providers and peers.

- Organize a manual or guide about the topic.
- Build an agenda to work in groups with providers.
- Organize a training for doctors and nurses about suicide prevention.
- Include trauma to talk about suicide prevention.
- Offer trainings to emergency rooms and crises intervention workers.
- Develop a questionnaire/survey for hospitals, clinics, providers asking questions after and before a suicidal crisis.
- Develop a protocol for the first response regarding suicide.
- Develop a tool with appropriate language to ask effective questions.
- Share resources.
- Develop a training for police officers.

Ensure equity and inclusivity

- Create a suicide advice board in each state.
- Partner with the Department of Health/Mental Health/Substance Abuse to develop trainings.
- The trainings will have facilitators with lived experience.
- Develop collaboration with minority communities regarding suicide prevention.
- Partner with the Department of Education.
- Partner with prisons and veterans to decrease the number of suicides.
- Include peers in research on suicide and suicide prevention.

Learning Collaboratives (Larry Davidson, facilitator)

The key questions presented to groups during this conversation were as follows:

- *Given the current work on Suicide Prevention in New England and our exploration of the role of peers supporting individuals in transitions of care, what do you think are the top priorities for a learning collaborative?*
- *Who would be the target audience(s)?*
- *How do we ensure equity and inclusivity?*

The groups identified both training topics and other areas for improvement, in order to support peers.

Training content

- Motivational Interviewing, when done well and with fidelity, is helpful. If not used appropriately, it can become coercive.
- Customer service skills
- Intentional peer support
- Patient's Rights (including their right to go outside, 6 fundamental rights.)
  - Training should include the 6 fundamental rights around visitation
- Group process:
  - How do we hold it? in group?
  - How do we use our stories effectively?
- Certified Peer Specialist (CPS) curriculum, what should it include/what does it leave out
  - CPS training is limited, needs to incorporate suicide prevention
- How do we advocate for roles in systems change?
- How do we sit in meetings with clinicians/how to advocate?
- Boundaries (e.g., how to balance when you've got boundaries w/non-peer staff)
- How much training should peers be put through? Too much may do same damage as too little.
- Alternatives to Suicide
- Ways to understand the root of suicide:
  - Trauma and suicide often go hand-in-hand. Suicide is one response to many life problems. Addiction is another.
  - Important to understand that suicide makes sense to some people at some times. It's not our place to define it.
  - Understanding the problem behind the suicidal ideation
    - What is going on in their lives? what would suicide solve for them?
  - Interdisciplinary. People at all levels, get placed together, talk about the impact of trauma, powerlessness, re-traumatization supporting people to address trauma.

Training structure

- Having trainings done that include multiple roles-explaining what peers do-they do different things, but they are important and valid
  - "Who gets to be in charge?"
- Two days of face-to face training, followed by month-to month trainings
- There are pros and cons of having peers and non-peers together and separated during trainings. Sometimes having meetings w/non-peer and peers, the conversation can get sidetracked from peer needs
- Bring back the info from the learning collaborative, keep in touch, not lose touch
- One size fits all may not be the best approach
- Seen best supports hijacked because professionals claim exclusive expertise

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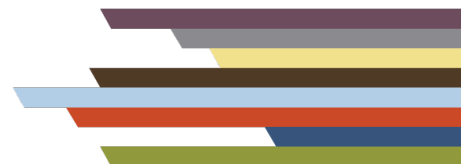
Training Approach

- Hearing what works for people vs. telling people what works
- We should be in a place that we'll learn together and share the experience
- Non-judgmental, validating experience
- Hearing the story and their needs
- Connection/rooted in the present
- Creating safe spaces for leaders to discuss/understand liabilities
- Quality of connection
  - We've become siloed, don't know what real connection is, no way to quantify it
- We don't always ask the right questions
- A peer would not be about "suicide prevention"
  - Can interrupt ideation by being with someone in the moment
  - Listening to the pain and exploring suicide in its particular meaning for individual

Funding/champions

- How to influence state-level leadership support to keep things moving/funding/who will support it
- To ask leadership to make the change, we have to decide what that change should be. Topics gets fogged by a social movement becoming condensed into a paid position (e.g., peer supporter) that hasn't yet been well-defined.

Systems Change

- Need clarity of purpose for buy-in when we go to leadership
- What language do we use to get that buy-in?
- Cost-benefit analysis, a measurement of success
- Need to look at system change from both micro and macro perspectives
- Get paid a living wage
- Buy-in from the top (e.g., CEO, president) trickles down
- If your supervisor doesn't sit in at the managers meeting, are you being valued?
- Giving advocates the information, use their skills to further buy-in
- Integrate peers in every role, every spot, for what works for them
- Every mobile crisis team has to have a peer with them on a call
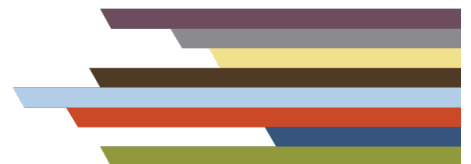
- Peer bridger, who goes into units, so that then person can continue with them when they are out of inpatient services
- Make sure peer bridgers aware of what resources are available in the community
- The danger of transitions in care is that people's symptoms may have been treated, but not the underlying cause.
- Develop transition process
- Take the time to listen to people-hospital doesn't always work for people
    o It can be traumatizing/ re-traumatizing
- Young people are a huge part of the efforts
- Peers that can challenge the system, can talk in a crisis team meeting to advocate for people "who's in the room?" checklist of who is being included

Part 7 | Where do we go from here as a region?

The Symposium concluded with a short conversation to debrief the contents of the day and to outline possible ways for the region to move forward. New England MHTTC plans to gather additional information about ways to integrate peers into suicide prevention work, as well as reflect on its role in light of the conversations begun at the Symposium.
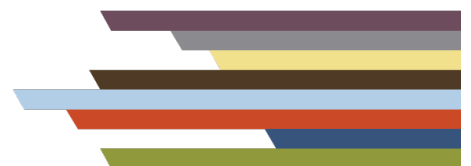
Acknowledgements

This symposium was conceived over the course of numerous conversations with nearly 100 stakeholders and organizations around New England. We appreciate their guidance and are humbled by the important work that they do every day. In addition, we want to thank Lee Locke Hardy and Vanessa Wronski for their logistical support in ensuring that the symposium ran smoothly.

Speaker Bios

Larry Davidson is a Professor of Psychiatry at Yale University and the Director of the Yale Program for Recovery and Community Health (PRCH) and the New England MHTTC. His research and consultation/training work focuses on processes of recovery from and in serious mental illnesses and addictions and the development and evaluation of innovative policies and programs to promote the recovery and community inclusion of individuals with these conditions. His team utilizes mixed qualitative and quantitative methods, and typically conduct their research in a participatory and inclusive fashion that involves people in recovery and other stakeholders in all aspects and phases of the research process.

Livia Davis is the Chief Learning Officer at the Center for Social Innovation (C4), responsible for the development and ongoing management of learning strategies and organizational capabilities needed to ensure alignment with strategic direction. She also serves as C4's lead for the SAMHSA's State Targeted Response (STR) Technical Assistance Consortium, which provides the resources and technical assistance needed to address opioid use disorder prevention, treatment and recovery nationally. In her six years as Project Director for SAMHSA's Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS), Livia was responsible for implementing a strategic approach to bringing recovery-oriented systems, best practices and programs to scale nationally. Livia has over 14 years of experience as a direct service provider working in behavioral health, housing, and homeless services. She also has first-hand experience working in a large recovery community in Denmark (started by her great-grandfather in 1912), which influenced her passion for recovery.

Paul Hammer is a Research Associate at the Yale Program for Recovery and Community Health (PRCH). Among other projects, he organized a conference at Yale in 2018 on Reasonable Accommodations in the Workplace under the ADA for persons with mental health conditions. Paul survived a suicide attempt in 2004 and at this point in his recovery is hoping to provide peer support to others who are at risk for suicide. He is currently enrolled in Advocacy Unlimited's Recovery Support Specialist Training Program in Connecticut. Paul is working on a play about suicide and suicide prevention, excerpts of which will be presented at today's Symposium. Paul has worked in marketing and in the social services for most of his life. He served as President of the Connecticut Bicycle Coalition and founded the bicycle recycling program at Connecticut Mental Health Center. He is a member of a Depression Bipolar
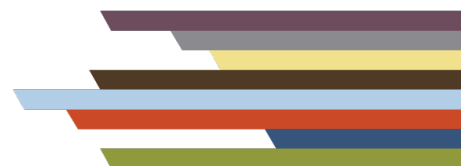
Support Alliance (DBSA) support group in Branford, Connecticut. Paul holds a B.A. in Theater and Government from Wesleyan University and a Master's in Public and Private Management from the Yale School of Management.

Michael Hogan served as State Commissioner of Mental Health for New York, Ohio and Connecticut and totaled one of the longest tenures in these key leadership positions. Previously, he chaired the President's New Freedom Commission on Mental Health in 2002-2003. Dr. Hogan served as the first mental health representative on the board of The Joint Commission (2007-2015). This remarkable experience as mental health pioneer all came together when Dr. Hogan was asked to join the National Action Alliance for Suicide Prevention in 2010. He and David Covington began partnering together on the task force which published the Suicide Care in Systems Framework. These two co-leads went on to give more than a hundred presentations in multiple countries spreading the transformative message of Zero Suicide. Together with Dr. Julie Goldstein Grumet, David Covington, and the team at the Education and Development Center (EDC, Inc.), Dr. Hogan was the primary architect for the ZeroSuicide.com website and its 7-element toolkit and fidelity framework for replication.

Karen Kiley is a Peer Support Specialist, Beacon Health Options. Karen worked for the Town of Windsor CT for 27 years, however, her battle with alcohol ended that career and dreams of retirement. After many hard times, including; multiple AMA (against medical advice) events while in treatment, serious medical issues, loss of home and employment, Karen accepted her addiction and began her recovery journey in August of 2005. Karen came to Beacon Health Options from Rushford Behavioral health where she worked as a Case Manager. Karen relayed that when in treatment a Clinician gave me hope for the future and faith in me when I did not have any in myself. This is what the Beacon CT Peer Team conveys to our Medicaid Members who are battling with their life issues and living their recovery journey. Karen is an active member of the Central CT Health District Recovery Workgroup.

Valerie Lepoutre is the Young Adult Programs Coordinator at NAMI Connecticut. Valerie is a certified Recovery Support Specialist who brings her own personal lived experience to her work to inspire, advocate, and educate others about mental health and suicide awareness. In addition to managing all of the Young Adult related programs at NAMI Connecticut, she also partners with many other young adult initiatives and organizations across the state. Her goal is to increase peer-support services for emerging adults and offer hope to those affected by mental illness and suicide loss.

Caroline Mazel-Carlton has laid her head in a number of places, from Indiana jail cells to Texas psychiatric units, but now enjoys a freer existence as Director of Training for the Western Mass Recovery Learning Community. She has been redefining peer roles in diverse settings and disparate parts of the world for over a decade. Her work with Alternatives to Suicide and the Hearing Voices Network has been featured in publications such as The New York Times, Foreign Policy, and O, The Oprah Magazine. She is passionate about reclaiming cultural and spiritual wisdom traditions for navigating extreme states, and is both certified as a Spiritual Emergence coach and studying to become a rabbi.

Maria E. Restrepo-Toro is an Educator, Manager of Training and Education at the Yale Program for Recovery and Community Health and Manager of the New England

MHTTC. Maria is a visionary leader, trainer and researcher in the fields of Latino Behavioral Health Recovery, Psychiatric Rehabilitation and Cultural Diversity. Maria is passionate about eliminating global mental health disparities, empowering people to recover, and gain equal access to behavioral health services. Maria has successfully trained bilingual professionals, administrators, peers, advocates and family members both nationally and internationally. She has a unique expertise in developing culturally appropriate recovery-oriented training materials designed to bring hope and to empower Spanish-speaking people and their families.

Katie Volk has been focusing on poverty and related issues since 2000. Currently a Senior Project Director at C4 Innovations, she has worked with hundreds of community organizations to provide training and technical assistance in the United States and Australia, particularly focused on implementing trauma-informed practices. Katie is the C4 site director for the New England Mental Health Technology Transfer Center (New England MHTTC) and a Principal Investigator on a National Institute of Child Health and Human Development (NIHCD) grant, through which C4 is developing an ecological, neurodevelopmental, psychometrically validated assessment tool for use with children in low-resource settings. She has a joint Master of Arts from Tufts University in Child Development and Urban Policy and an undergraduate degree from the College of the Holy Cross.